

DOCTORAL THESIS

Shared decision-making in counselling and psychotherapy

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Shared decision-making in counselling and psychotherapy

by

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A thesis submitted in partial fulfilment of the requirements for the degree of

PhD

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Abstract

Shared decision-making (SDM) is a process for making treatment decisions in healthcare based on a patient's informed preferences and a practitioner's knowledge. This thesis examined SDM in counselling and psychotherapy; with three aims. First, to identify the process by which therapists and clients share decisions. Second, to understand how clients experienced SDM. Third, to evaluate the impact of SDM. Four studies were undertaken to achieve these aims.

First, a systematic review examined SDM literature in counselling and psychotherapy. This found no evidence of a positive relationship between SDM and clinical outcomes. However, there were limited indications that SDM was positively related to reduced arousal, reduced hostility, and greater therapist-rated alliance.

Second, a Grounded Theory approach using Interpersonal Process Recall interviewing investigated 14 clients' experiences of SDM in pluralistic therapy for depression. This indicated that most clients were comfortable taking part in shared decision-making and felt their therapist's actions supported them to take part in that process.

Third, a Conversation Analysis examined goal negotiations within six therapy dyads. When alignment occurred, dyads worked together to decide relevant goal content. When misalignment occurred, therapists facilitated client involvement by building them towards a contribution, providing accounts, and suggesting candidate answers.

Fourth, multilevel models were developed for psychotherapy outcomes using SDM observation ratings for 14 clients. This found a trend in which higher SDM scores were associated with greater reductions in anxiety and depression over the

course of therapy, greater goal attainment, greater therapist satisfaction, and higher ratings of session effectiveness.

This thesis showed that therapists can adopt a hierarchy of methods to facilitate clients who want to take part in the SDM process but have difficulty doing so. Clients' preferences for conducting SDM may change across clients, across decisions. Moreover, SDM may have a beneficial clinical and experiential impact on clients.

The research for this project was submitted for ethics consideration under the reference PSYC 16/ 229 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 05.10.2016.

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Chapter one: Introduction

Clients and patients have an intimate knowledge of themselves and what they prefer. A therapist can benefit from this knowledge and use it alongside their specialist psychotherapy knowledge to inform a client's treatment. By sharing their knowledge with each other, both parties can work towards an ideal decision for how to help a client with the difficulties they bring to psychotherapy. Shared decision-making is one approach for working in this way and is already established in the fields of healthcare and mental health. This thesis will investigate shared decision-making adapted for a counselling and psychotherapy context. In doing so, I aim to offer an understanding of the approach that can be of practical use for therapists seeking to use shared decision-making in counselling and psychotherapy.

Defining shared decision-making

Shared decision-making has been described as the ideal clinical decision-making model for healthcare decisions, and contrasts with *paternalistic* and *patient-informed models* (Emanuel & Emanuel, 1992; Barry & Edgman-Levitan, 2012). Practitioners using paternalistic models draw on their professional knowledge to make recommendations for improving a patient's well-being (Emanuel & Emanuel, 1992; Veatch, 1975). As such, paternalistic models limit a patient's role to that of a consent-provider. Conversely, practitioners in patient-informed models offer unfiltered lists of available treatments, without making recommendations (Emanuel & Emanuel, 1992). Patients in patient-informed models make recommendations based on their preferences and therefore have increased decision-making authority. Using patient preferences in decision-making moves patient-informed models closer to shared models. Nevertheless, patient-informed models restrict a practitioner's role to that of an option-lister. In contrast, shared decision-making uses both a

practitioner's and a patient's contributions to arrive at mutual agreements (Charles, Gafni, & Whelan, 1997). In this way, shared decision-making ensures neither party is restricted to a role of consent-provider or option-provider. Doing so moves the decision-making process closer to an ideal speech situation where talk is not distorted by intentions to control, but where those involved look for authentic involvement from each party in the decision-making (Habermas, 1979).

Healthcare definitions of shared decision making.

The conceptualisations of shared decision-making in healthcare have implications for investigating the approach within psychotherapy. Charles et al. (1997) offer four criteria for sharing decisions. First, that the decision-making process involves a minimum of both patient and practitioner. Additional participants may include family, carers, or clinical team members. Second, parties exchange information including available treatments, patient preferences, and patient values. Third, parties move towards a consensus through a process of deliberation. When deliberating, practitioners should share recommendations and encourage a patient's treatment preference, if appropriate. Charles et al. (1997) suggest that practitioners be mindful of imposing their views during deliberation. Last, parties mutually agree on a final decision. The decision could be to do nothing or to seek advice from another practitioner.

Makoul and Clayman (2006) later reviewed definitions of shared decision-making used within healthcare practice and research. They conducted a systematic review of articles that addressed shared decision-making in medical contexts. Articles were eligible if they were published in English and used the term 'shared decision-making' in the context of a provider-patient relationship. Makoul and Clayman showed that 38.5 percent of articles contained a conceptual model of

shared decision-making ($k = 161/418$). These models included those from Charles et al. (1997), Coulter (1997), Towle (1997; 1999), and Elwyn et al. (2000). These shared decision-making models contained the terms ‘options’ (50.9% $k = 82/161$) and ‘patient values’ or ‘patient preferences’ (67.1% $k = 108/161$). However, there was no universal shared decision-making model across the included articles. Makoul and Clayman (2006) therefore integrated the models of shared decision-making to offer characteristics of the approach. First, a practitioner and patient define the problem. Second, a practitioner presents all available options and a patient offers any additional options. Both parties then discuss the advantages and disadvantages of the options. Next, parties discuss the options considering the practitioner’s knowledgeable recommendations and the patient’s concerns, expectations, preferences, and values. They also discuss the patient’s self-efficacy to follow through with any decided action. Both parties then reach agreement during their meeting or in a later consultation. Following agreement, parties arrange a follow-up meeting to track the outcome of the decision or to discuss any deferred decisions. The practitioner checks the patient’s understanding and perspectives throughout the decision-making process. Makoul and Clayman’s (2006) integrative model recognises the potential for decisions to be deferred and agreed at a later meeting, implying that shared decision-making could be an ongoing process.

Coulter and Collins (2011) refine Makoul and Clayman’s (2006) integrative model to offer a comprehensive definition of shared decision-making:

‘a process in which clinicians and patients work together to select tests, treatments, management, or support packages, based on clinical evidence and the patient’s informed preferences’ (p. vii).

The present thesis is informed by Coulter and Collins' (2011) definition. This is due to the definition drawing on developments from past researchers in conceptualising shared decision-making (Charles et al., 1997; 1999; Towle and Godolphin, 1999; Elwyn et al., 2000). Such developments resulted in a definition that can provide a basis for moving the concept of shared decision-making into a psychotherapy context. However, maintaining an awareness of the original core elements from Charles et al. (1997) will enhance the validity of any investigation of shared decision-making within psychotherapies.

Metacommunication and metatherapeutic communication.

Definitions of collaborative communication in psychotherapy suggest differences between how shared decision-making is defined in healthcare and psychotherapy. For example, research within psychotherapy suggest a greater emphasis on collaborative alignment and metacommunication during shared decision-making, in comparison to conceptualisations within healthcare. Collaborative alignment is implicit within Charles et al.'s (1997; 1999) conceptualisation. The ways such collaborative talk is used in both psychotherapy and healthcare can explain this greater emphasis. Medical professions have counselling and the use of counselling skills embedded within them but are not the aim of the interaction (McLeod & McLeod, 2011). Often, patients in medical interactions report symptoms to a practitioner in seeking a solution for a difficulty (Goffman, 1968). It is then likely that one medical practitioner will then treat those symptoms. Whereas in psychotherapy, a client's difficulties are often identified through joint exploration or the therapist's interpretations (Bercelli, Rossano, & Viaro, 2008). Therapists and clients then work together to resolve these difficulties in subsequent psychotherapeutic interactions (Peräkylä, Antaki, Vehviläinen, &

Leudar, 2008). Thus, using shared decision-making in psychotherapy to identify and resolve a client's difficulties requires more extended, collaborative talk than in a medical context.

A therapists and client can use such collaborative talk to discuss psychotherapy *process* using metacommunication. (Rennie, 1998). Process refers to the cognitive or behavioural 'activities in which clients engage as they work with their experience from moment-to-moment' (Rennie, 1998, p. 70). Rennie suggests therapists and clients can use four forms of metacommunication. These forms consist of a therapist giving the purpose behind their talk; a therapist offering how they are reacting to the client's talk; a therapist querying the purpose behind a client's talk; or a therapist asking how their talk is impacting a client. Therapists often initiate metacommunication when they feel it could benefit the therapeutic work. Yet, both therapists and clients can begin metacommunications. Metacommunication shares similarities with a shared decision-making process by encouraging a therapist and client to share opinions and intentions. However, metacommunications are not limited to decision-making talk.

Cooper and McLeod (2007; 2011) adapt metacommunication to therapy decision-making and suggest it to be synonymous with shared decision-making. They introduce the term *metatherapeutic communication* whereby a therapist and client can step out of the flow of conversation to comment on their talk and actions (Cooper & McLeod, 2011; 2012). Cooper and McLeod (2012) proposed metatherapeutic communication to be a process of 'talking to clients about what they want from therapy, and how that might be achieved' (p. 7). As such, metatherapeutic communication is a dialogue between a therapist and client about goals and methods for therapy (Cooper et al., 2015). Cooper and McLeod (2011) encourage therapists

and clients to share decisions throughout treatment using ongoing metatherapeutic communication. Later, Papayianni and Cooper (2017) code metatherapeutic communication on three dimensions. The first dimension is the subject matter of the communication, consisting of: content of the talk, goals, methods, a client's experience, or understandings of a client's difficulties. The second dimension is the temporal focus of the communication, such as the current or previous session. The last dimension is the time in a session that metatherapeutic communication took place. Papayianni and Cooper's (2017) three dimensions imply metatherapeutic communications happen during decision-making that likely affects the direction of the session or treatment. Together, these works suggest that metatherapeutic communication is a synonymous concept with shared decision-making. Therefore, a decision-making process without metatherapeutic communication could not be considered shared.

The research findings from psychotherapy suggest shared decision-making is an ongoing process. Whereas, Charles et al.'s (1997), Towle and Godolphin's (1999), and Elwyn et al.'s (2000) shared decision-making frameworks do not explicitly propose an ongoing process. The structure of psychotherapy treatment can explain the differences between how shared decision-making is conceptualised in healthcare and psychotherapies. For example, a single therapist in psychotherapy will often assess and engage in treatment with a client. The same therapist will work with that client on multiple difficulties throughout treatment. Conversely, medical interactions are often one meeting with a single practitioner. Multiple practitioners will often work with a patient experiencing multiple difficulties. An exception within healthcare is the continual shared decision-making relationship suggested in managing long-term conditions (Coulter et al., 2015). Therefore, any shared

decision-making definition for psychotherapies should include the possibility of an ongoing process. Acknowledging this ongoing process would avoid shared decision-making becoming a tick-box exercise to be used only once.

Best practice of shared decision making in healthcare.

Proponents of shared decision-making have expanded upon the conceptualisations and definitions of the approach to offer guidelines for best practice. For example, Charles, Gafni, and Whelan (1999) proposed updates to their 1997 definition for the information exchange and deliberation within shared decision-making. They propose practitioners should share all decision-relevant information, including: available treatments, benefits and risks, and the potential effects on a patient's well-being. Practitioners and patients should deliberate on the available options considering the patient's circumstances, needs, and preferences. During deliberation, practitioners and patients can persuade each other to a preferred option. However, each party should recognise the other's views and why they might be different.

Towle and Godolphin (1999) build on Charles et al. (1999) by adding greater consideration for patients' decision-making preferences. Central to these guidelines is a practitioner developing a partnership with their patient and explaining that both will share any decision-making. Within this partnership, a practitioner should establish a patient's preferences concerning risk-taking, the amount and format of information, and the amount of involvement from themselves and others in the decision-making. A practitioner should ask for and respond to a patient's ideas, uncertainties, or expectancies about the decision. Next, both parties should identify all available choices. A practitioner should present evidence for the identified choices, directing a patient to further evidence. Both parties should then evaluate the

choices alongside the research evidence and the patient's circumstances. During deliberation, the practitioner should help a patient to reflect on the impact the decision could have on that patient's lifestyle and values. Towle and Godolphin (1999) suggest that parties resolve any conflicts before making an agreement. On reaching an agreement, both parties should arrange a follow-up consultation. Towle and Godolphin's (1999) guidelines are aligned with Charles et al.'s (1997; 1999) conceptualisation of shared decision-making. However, Towle and Godolphin propose a greater focus on accommodating for a patient's preferences for how their practitioner delivers information, as well as how much information they receive. There is also a greater focus on accommodating for how much patients want to be involved in the shared decision-making process and the roles they would like to adopt within that process.

Elwyn, Edwards, Kinnersley, and Grol (2000) later suggested amendments to the order of the steps for performing shared decision-making proposed by Charles et al.'s (1997; 1999) and Towle and Godolphin (1999). Elwyn et al. (2000) conducted focus group interviews with six general practitioners. These practitioners had read both Charles (1997) and Towle and Godolphin (1999) prior to interview. The practitioners' views led Elwyn et al. (2000) to suggest amendments to Towle and Godolphin's (1999) framework. For example, a practitioner should present available options before eliciting a patient's preferences for involvement. Doing so would avoid a patient offering involvement preferences before they know what choices they face and prejudging the decision-making interaction. The practitioners Elwyn et al. interviewed reported a preference for using implicit communication techniques to explain patient involvement, rather than explicit techniques. For example, one practitioner recommends against explicitly stating to a patient: 'I'm involving you in

a shared decision’, suggesting instead the implicit technique of: ‘There are several treatments that we could use here and I’ll run through them and see which one suits you best’ (p. 894). Other practitioners suggested recurrently checking patient understanding of technical information throughout the decision-making. Together, these three amendments suggest a shared decision-making framework that is more dialogical and closer to extended interactions typical of a psychotherapy context.

Coulter and Collins (2011) accompany their definition of shared decision-making with guidelines for how practitioners should perform the approach in a consultation. These guidelines suggest a practitioner and patient should: negotiate agenda-setting and priorities; exchange decision-relevant information and choices; discuss incorrect or unhelpful patient health beliefs, if appropriate; communicate and manage risk; support deliberation; summarise and make the decision; and document the decision. Throughout this process, a practitioner should develop empathy and trust with their patient. These guidelines adopt a greater focus on a practitioner supporting a patient throughout the decision-making process, in comparison to previous conceptualisations of shared decision-making. This is due to such support previously being suggested to only including checking patient understanding of technical information (Elwyn et al., 2000) or having a period for discussing patient expectations and uncertainties (Towle & Godolphin, 1999).

Coulter (2017) further focuses on the relationship between a practitioner and patient during shared decision-making to suggest that the approach is a continual relationship between the two parties. This relationship would include a series of discussions across multiple meetings, typically over an extended period. Coulter (2017) supports her stance with evidence from a systematic review of personalised care planning trials for adults with long-term conditions (Coulter et al., 2015).

Coulter et al. (2015) viewed personalised care planning as making long-term condition management decisions in line with a patient's values and concerns. This decision-making occurs throughout regular, scheduled meetings between a practitioner and patient. These practices suggest an approach to shared decision-making that would be more appropriate for psychotherapies, where a therapist and client might discuss ongoing decisions over multiple treatment sessions.

Recommendations for the practice of shared decision making in counselling and psychotherapy.

Suggestions for how shared decision-making should occur in a psychotherapy context build on the suggestions for practicing the approach in healthcare. For example, both parties should exchange decision-relevant information (Kenny, 2012; Osei-Bonsu et al., 2016). The exchange should move the client towards becoming informed about what the decision might mean for their therapy (Barr, Forcino, Mishra, Blitzer, & Elwyn, 2016; Chong, Aslani, & Chen, 2013; Osei-Bonsu et al., 2016). Next, there should be a collaborative alignment between both parties (Bachelor, 2013; Cooper et al., 2015). Both parties should work towards a consensus, although remain open to shared decision-making as an ongoing process (Osei-Bonsu et al., 2016). Last, any decision made should accommodate for a client's preferences, circumstances, and values (Cooper et al., 2015; Ekberg & LeCouteur, 2014).

Two studies suggest that a therapist and client should exchange decision-relevant information during collaborative therapy and shared decision-making (Kenny, 2012; Osei-Bonsu et al., 2016). Osei-Bonsu et al. (2016) attend to Elwyn et al.'s (2010) recommendations and suggest practitioners should offer evidence for available treatment options. Kenny (2012) reported that clients wanted this

information exchange to occur in their discussions with their therapist. For example, one client reported a desire to know what the available psychotherapy models entailed for themselves and their treatment. The same client reported being aware of the need to make a good decision because of the impact the decision could have on their future.

Both Chong et al. (2013) and Osei-Bonsu et al. (2016) suggest that shared decision-making should help clients to make informed decisions. Moreover, Barr et al. (2016) shows that both clients and practitioners think a client should gain an understanding of practical information about treatment options. This information could include: the likelihood of the treatment working; potential side effects; financial cost implications; and expected recovery time.

Cooper et al. (2015) and McKay (2011) propose that a therapist and client should use *metacommunication* and work towards a collaborative alignment. Metacommunication refers to communicating about the communication occurring (Rennie 1998; Safran, Muran, Samstag, & Steven, 2002). Cooper et al. (2015) propose that a therapist and client collaboratively talk about how best to meet a client's goals and wants. Similarly, McKay (2011) suggests clients participate in metacommunication with their therapist about their preferences for discussing potential concerns of how the two are working together.

Osei-Bonsu, et al. (2016) suggest a therapist and client should treat shared decision-making as an ongoing process. Osei-Bonsu et al. (2016) refers to organisational guidelines for shared decision-making in treating post-traumatic stress disorder. These guidelines encourage therapists to continue selecting methods and developing their collaborative relationship with clients throughout treatment.

Two studies suggest that shared decisions should accommodate for client preferences. Cooper et al. (2015) suggest that a therapist and client reach treatment decisions that reflect the client's therapeutic goals and preferences Ekberg and LeCouteur (2014) demonstrate this accommodation of client preferences does occur in practice. They showed that therapists acknowledged clients' preferred suggestions within the decision-making process.

Adapted shared decision-making definition for psychotherapies.

Together, the research examining shared decision-making in healthcare and psychotherapy suggest there are differences in conceptualisations of the approach for each context. Moreover, there are differences between the two contexts in how practitioners feel the approach should be performed. As such, it would be appropriate to adapt definitions of shared decision-making from healthcare to a psychotherapy context. Such an adapted definition should accommodate for the possibility of decisions around therapy activities, methods, and goals. This definition should also accommodate for the possibility of shared decision-making as an ongoing process. Therefore, Coulter and Collins' (2011) definition of shared decision-making can be adapted for psychotherapy to be defined as: an ongoing metatherapeutic dialogue in which a therapist and client work together to select therapy directions, methods, or support based on a client's informed preferences, a therapist's expertise, and the clinical evidence when appropriate.

This adapted definition adds two considerations when making shared decisions. These include the use of a therapist's expertise and the appropriateness of presenting clinical evidence. The additions can accommodate for instances where a therapist's expertise and a client's preferences may make discussing clinical evidence inappropriate. For example, when deciding at the start of a therapy session

whether to discuss a client's unforeseen distressing event, or to adhere to a previously planned structure. The therapist not forcing a discussion of clinical evidence aligns with Rennie's (1998) recommendation to avoid excessive metacommunication, as this can disrupt the therapeutic process. Yet, the adapted definition retains the discussion of clinical evidence, when appropriate. For example, a therapist and client discussing clinical evidence to agree which methods could help the client move towards their therapy goals. Together, these additions advance on Coulter and Collin's (2011) definition of shared decision-making by offering greater detail about the expectations of a therapist and client in the shared decision-making process.

The potential differences between conceptualisations of shared decision-making in healthcare and psychotherapy suggest a benefit to examining how the approach occurs in psychotherapy practice. This is also supported by the differences between the recommendations from both contexts with regards to the best practice of shared decision-making. Such an examination would be useful for evaluating the validity of the adapted shared decision-making definition. First, by determining if the characteristics of shared decision-making are transferable from healthcare. Second, by determining whether the adapted definition aligns with how therapists and clients share decisions in practice. For example, whether shared decision-making is practiced as an ongoing process containing metatherapeutic communication that maintains a collaborative alignment.

Shared decision-making as desirable practice

Healthcare and mental health practitioners' perspectives.

Research in helping professions suggests shared decision-making is likely an ideal treatment decision-making process. The perspectives of healthcare and mental

health practitioners support this stance, showing the approach to be desirable in practice. Practitioners' perspectives on shared decision-making support practicing and researching the approach. Pollard, Bansback, and Bryan (2015) demonstrated positive practitioner attitudes towards shared decision-making. Pollard et al. (2015) systematically reviewed 43 qualitative and quantitative studies published between 2007 and 2014. These studies took place in primary and secondary care. Pollard et al. (2015) report one study with a United States representative sample of surgical practitioners that showed a neutral comparison between shared decision-making and paternalistic models (Odds ratio: 0.74, 95% CI: [0.43, 1.29], N = 1,050). However, practitioner samples overall held positive attitudes towards shared decision-making. Studies comparing treatment decision-making models showed that a majority of practitioners held a preference for either shared decision-making or a model advocating patient involvement in decision-making ($n = 14/17$, 82%).

Elywn, Edwards, Gwyn, and Grol (1999) report junior practitioners' views of shared decision-making before and after using it. Some practitioners held reservations about shared decision-making whilst others were more receptive. Other practitioners deferred to their professional judgement as they saw patient participation in treatment decisions as unrealistic. Whereas, others using shared decision-making felt their patients had become more informed about the treatment decision. Those practitioners using the approach felt their patients had taken an involved role in the decision-discussions. Some practitioners reported holding an underlying assumption that their patients do want to be involved in treatment decisions. Elwyn et al.'s (1999) findings suggest that the medical community both accepted and resisted shared decision-making. Although, practitioners that were accepting of the approach found it to be rewarding.

Towle, Godolphin, Grams, and LaMarre (2005) show that family practitioners viewed shared decision-making positively. Towle et al. (2005) analysed transcripts of family practitioner interviews and consultations following shared decision-making training. Practitioners regarded shared decision-making after their training as positive and worth practicing. Similarly, transcripts of consultations showed that practitioners felt encouraged to continue using shared decision-making when a patient responded positively to the process. However, a barrier to shared decision-making included the need for practitioners to change established communication patterns with patients. Towle et al.'s (2005) findings suggest that practitioners want to use shared decision-making, but that this can take time to implement fully.

Castillo-Tandazo et al. (2016) present practitioners' positive views of shared decision-making that are aligned with the findings of Elwyn et al. (1999), Towle et al. (2005), and Pollard et al. (2015). A cross-sectional sample of 152 Ecuador-based practitioners offered survey responses. A majority of the practitioners were aware of conceptualisations of shared decision-making (69.1%, $n = 105/152$). A minority reported never practicing shared decision-making (5.7%, $n = 6/151$). Practitioners evaluated shared decision-making as very positive ($n = 69/105$, 65.7%), somewhat positive ($n = 27/151$, 25.7%), or offered a neutral response ($n = 9/151$, 8.6%). No practitioners viewed shared decision-making negatively. Castillo-Tandazo et al.'s (2016) findings imply shared decision-making is seen as a positive practice across healthcare in different nations.

Collectively, the works of Towle et al. (2005), Pollard et al. (2015), and Castillo-Tandazo et al. (2016) suggest that practitioners see shared decision-making as a desirable practice. However, shared decision-making is inclusive of both

practitioner and patient. Therefore, it would be useful to examine how clients perceive and experience the approach. Clients' experiences should be compared to the practitioners' experiences from research in other helping professions to gain a preliminary understanding of how shared decision-making is experienced by all parties.

Client and patient perspectives.

Patients view the desirability of shared decision-making similarly to practitioners. Edwards (2001) reports focus group data from United Kingdom patients and patient representation groups. The focus groups supported the idea of patient involvement in decision-making and wanted to be involved in the decisions around their care. They also expressed a desire for having a range of treatment options available to them. However, the sample of patient representatives could have been biased towards patient involvement in treatment decisions. Edwards (2001) recognises similar limitations, suggesting the benefit of individual interview methods for future research.

Similarly, patient reports from national United Kingdom surveys show patient involvement in decision-making as desirable and occurring. Forty-four to 48 percent of patients in the past decade of national inpatient surveys reported wanting more involvement in their care decisions, with the remainder satisfied with their involvement (Ahmad, Ellins, Krelle, & Lawrie, 2014). As such, these findings imply United Kingdom patients see their involvement in decisions as desirable. Furthermore, patients are increasingly experiencing this involvement over the past decade.

Mental health and psychotherapy findings shows that some clients do want to take part in their treatment decision-making. Adams (2007) surveyed 30 adult clients

from community care settings living with severe mental illness. These clients reported wanting more involvement in their psychiatric care decisions than they had previously experienced. Clients were less likely to prefer a passive role in their psychiatric care decisions than in general practice. Twenty-three percent of clients ($n = 7$) preferred a passive role in psychiatric medication decisions, compared to 77 percent in general medical care ($n = 23$; $z = -3.01$, $p = .003$). Similarly, Kenny (2012) reports an interpretative phenomenological analysis of interviews with five psychotherapy clients. One client reported their views on collaborative aspects of treatment. This client expected to hold a central, collaborative role alongside their therapist. This client expected to have this role throughout treatment, that would be inclusive of decisions for how that treatment occurred.

Clients' desires for collaboration and involvement in treatment decisions are not limited to individual treatment. Sundet (2011) offers a grounded theory analysis of family therapy from a Norwegian outpatient setting. Families reported one helpful aspect to be having choice around the organisation of the therapeutic work. These choices included how, where, when, and with what therapist to work with. Families also felt collaboration was part of a helpful relationship with their therapist. This collaboration consisted of families feeling their therapist had listened to them, heard them, took them seriously, and gave them opportunities to pursue preferred goals and methods. As such, these findings show that families indicated helpful aspects of their therapy that have similarities with shared decision-making. This implies that these clients had both a desire to be involved in their treatment decisions and found doing so to be helpful.

Together, these findings suggest most patients and clients want to be involved in their treatment decisions. The findings also imply that most clients see

shared decision-making as desirable practice. Therefore, it would be useful to the psychotherapy field to determine whether this desirability is aligned with clients' experiences of the approach in practice.

Ethical guidelines for counselling and psychotherapy.

Characteristics of shared decision-making are aligned with guidelines for ethical practice in counselling and psychotherapy, thereby suggesting the approach to be an ethical practice. For example, BPS (2005) counselling psychology guidelines share similarities with shared decision-making, but do not explicitly suggest the approach. These guidelines state that a practitioner should support a client's autonomy as well as supporting that client in making appropriate decisions. A practitioner should also respect the diversity of beliefs and values that a client could have. Having this respect ensures the practitioner would be open to any preferences or values a client could bring into decision-making. A practitioner should also be aware of the power dynamics between themselves and their clients.

Similarly, UKCP (2009) present ethical principles for psychotherapists that are aligned with a shared decision-making process. First, a practitioner should recognise a client's autonomy to engage with the therapy modality and treatment. As such, a client has choice in what therapy activities occur and what they participate in. Second, a practitioner should be aware of the diversity of clients, and how this diversity could affect treatment. Practitioners respecting client autonomy, capacity, and diversity would ensure that treatment decisions are led by the practitioner only. Third, practitioners should ensure they do not work with a client that cannot engage with the treatment due to physical or mental health reasons, including impairment through substances. With regards to shared decision-making, this would help ensure a client has the capacity to make informed decisions alongside their practitioner.

Fourth, the principles suggest a practitioner explains to a client the details of therapy decisions that need to be made. These decisions might include activities or methods, modality, treatment contracts, fees, or length of treatment. These explanations share similarities with the information exchange in shared decision-making and would assist clients to make informed decisions with their practitioner. Last, a practitioner should recognise the scope of their professional experience and skills. For example, a practitioner informing a client of any limitations in their skills where it may be appropriate to refer the client to another professional. With regards to shared decision-making, this recognition of limitations could help a practitioner avoid fulfilling a client-led decision to work in a way beyond their skills. Together, these principles show that characteristics of shared decision-making are implicitly recommended for ethical psychotherapy practice.

The British Association for Counselling Psychology present an ethical framework that implicitly encourages shared decision-making (BACP, 2016). The framework suggests a practitioner works in a partnership with their client that encourages that client's autonomy. This includes the practitioner and client agreeing on how they will work together. In building this partnership, a practitioner should maintain an awareness of how a client is experiencing the work between them. The BACP suggests a practitioner communicates any benefits, costs, and commitments that a client can expect from both the practitioner and the treatment. A practitioner should also be willing to discuss any known risks in pursuing what a client wants to achieve in treatment.

Guidelines for treating adult depression advocate the use of shared decision-making. The National Institute for Health and Clinical Excellence recommends a practitioner and client collaboratively make depression treatment and management

decisions (NICE, 2009). NICE guidelines propose a client has a right to be involved in their treatment decisions and make informed decisions alongside their practitioner. NICE have drafted recent recommendations that add a greater emphasis on a client's capacity to give informed consent to take part in collaborative decision-making (NICE, 2017).

Together, the ethical frameworks and good practice guidelines for counselling and psychotherapy implicitly advocate shared decision-making. Pooling these guidelines shows four recommendations for good practice that are focused around characteristics of shared decision-making. First, a practitioner should recognise a client's autonomy and facilitate a client's ability to contribute to decision-making. Second, a practitioner should ensure a client can contribute to decision-making from an informed position. Third, any agreed decision should reflect a client's reasonable needs and a practitioner's skills. Last, a practitioner should be open to the variety of preferences and values a client can bring to treatment decision-making. As such, these ethical frameworks for counselling and psychotherapy imply shared decision-making is part of good practice. Therefore, it would be useful to examine whether the practice of shared decision-making in psychotherapy is aligned with these recommendations for ethical practice. For example, whether clients taking part in shared decision-making feel that the decisions reached are reflective of their needs and make use of their therapist's skills. Providing this understanding would contribute towards the ethical frameworks and subsequent practice being informed by evidence.

Effectiveness of shared decision-making

Impact of shared decision-making interventions.

Research examining shared decision-making in helping professions suggests that the approach could have a potential positive impact on treatment outcomes. For example, Joosten et al. (2008) systematically reviewed studies in healthcare and mental health contexts that compared shared decision-making interventions with non-shared decision-making interventions. They required studies to be randomised control trial designs with both an intervention and control group. Joosten et al. also required studies to contain one or more outcome measures for patient satisfaction, quality of life, treatment adherence, or well-being. They examined 11 randomised control studies. Five of these studies showed no difference between the two types of interventions for patient satisfaction ($k = 3$) and quality of life, anxiety, and general health status ($k = 2$). One study showed no positive short-term effects of shared decision-making on treatment outcomes but did find a long-term effect on well-being. Five studies showed a positive effect of shared decision-making on patient satisfaction ($k = 2$), increase patient knowledge ($k = 2$), depression outcomes ($k = 1$), and quality of life, anxiety and general health status ($k = 1$).

Later, Paraskeva et al. (2016) designed the Patients' Expectations and Goals: Assisting Shared Understanding of Surgery (PEGASUS) intervention. This tool aims for a patient and practitioner to create surgical and psychosocial goals before making decisions. Next, the patient rates the goals for importance. A practitioner then rates these goals for realistic outcomes at a later decision consultation. These goals and ratings then frame discussions between a patient and practitioner for selecting the best option. Parasekva et al. (2016) reports interviews with breast augmentation patients and practitioners using PEGASUS. Patients report the intervention to be relevant, comfortable, and helpful for making decisions. Practitioners felt the

intervention was useful for helping their patients reflect on goals and reasons for pursuing surgery.

Other research examining shared decision-making has shown that implementing the approach over multiple meetings is associated with positive benefits. Coulter et al. (2015) systematically reviewed personalised care planning trials for adults with long-term conditions. Included trials contained care as usual control groups where a practitioner did not explicitly involve a patient in the decision-making process. Eligible studies were also randomised controlled trials and cluster-randomised controlled trials. Coulter et al.'s (2015) reviewed 19 studies within both hospital settings ($k = 3$) and primary care or community settings ($k = 16/19$). Five studies of depression outcomes showed a pooled mean difference between intervention and control groups of -0.04 (95% CI [-0.05, -0.2]), with a small positive effect in favour of personalised care planning (0.2). Coulter et al.'s. (2015) findings demonstrate there are benefits to using shared decision-making as a continual process, over multiple meetings. Similarly, Ishii et al. (2017) examined practitioners and patients in an acute treatment setting that used a shared decision-making intervention to create ongoing care plans during weekly twenty-minute sessions. The intervention included three stages. A patient completed self-reports of their perceptions of their ongoing treatment. The patient and a practitioner then shared their perceptions of the ongoing treatment. Last, both parties worked towards a mutual decision for the subsequent week. The intervention showed marginally higher increased patient satisfaction at discharge, compared to a control group. However, Ishii et al. (2017) prematurely ended the trial due to slow enrolment.

Hamann, Holzhueter, Stecher, and Heres (2017) similarly show positive benefits from a multi-session shared decision-making intervention. The intervention

aimed to empower practitioners and patients to be active in the decision-making process. The intervention also aimed to help practitioners to empower their patients. Practitioners attended shared decision-making training workshops and weekly supervisions. These sessions taught practitioners about the conceptualisations and practice of shared decision-making. Sessions topics included: how to use the approach, negotiation skills, and tools for handling difficult decisions with their patients. Patients participated in shared decision-making training that familiarised them with the concept and taught communication skills. Patients also received a question prompt sheet to encourage their activity in later decision discussions. Hamman et al. (2017) report that although the trial is ongoing, positive outcomes are expected for perceived patient involvement and amounts of shared decision-making occurring.

Together, Joosten et al.'s (2008), Paraskeva et al.'s (2016), Ishii et al.'s (2017), and Hamann et al.'s (2017) shared decision-making interventions demonstrate positive outcomes for helpfulness, satisfaction, and patient involvement. Joosten et al. (2008) also showed shared decision-making interventions may have a potential positive effect on clinical outcomes. The interventions within these investigations implemented shared decision-making over multiple meetings or showed positive long-term effects on well-being. However, chapters three and six contain a more focused discussion of the likely impact of shared decision-making on psychotherapy outcomes.

The therapeutic alliance and shared decision-making.

The characteristics of shared decision-making for psychotherapies share similarities with components of the therapeutic alliance. For example, the alliance contains the components of a practitioner and client agreeing on therapy goals and

tasks (Bordin, 1979). Bordin (1979) suggests that dyads can achieve a collaborative relationship when these components are present. These components resemble shared decision-making, as both parties will be moving towards an agreed decision they think will help the client towards change.

Research examining the therapeutic alliance suggests it to have similar characteristics to shared decision-making. The Alliance Negotiation Scale (Doran, Safran, Waizmann, Bolger, & Muran, 2012) includes items for therapist and client agreement. There are also items referring to accommodation of a client's wants and needs. Doran et al. (2012) propose that a higher scale score corresponds to greater collaboration and a collaborative bond. Similarly, the Working Alliance Inventory (Horvath & Greenberg, 1989) contains a factor for agreement on therapy goals. This factor has items measuring mutual agreement on goals and what those goals would mean for the client. These items share similarities with the mutual agreement and metatherapeutic communication suggested within shared decision-making in psychotherapy. Bachelor (2013) later performed a cross-measure factor analysis of the working alliance, reporting six factors. Three of these factors have similarities to the characteristics of shared decision-making. First, clients' active commitment and participation in therapy shares similarities with client involvement and active participation in shared decision-making. A second factor consists of a non-disagreement between client and therapist on therapy goals and tasks. This second factor resembles both parties reaching a consensus through deliberation. Bachelor reports a third factor across therapist answered tools labelled client-therapist collaboration. Together, these works suggest that conceptualisations of the therapeutic alliance include characteristics of shared decision-making.

The quality of the therapeutic alliance is associated with a positive impact on psychotherapy outcomes, including the effectiveness of therapeutic work (Norcross, 2011; Wampold, 2015). For example, Martin, Garkse, and Davis (2000) report their meta-analysis that showed a positive relationship between clinical outcomes and the strength of a dyad's alliance. This positive relationship held true whether a client, therapist, or observer rated the alliance. Flückiger, Wampold, Symonds, and Horvath (2012) supported Martin et al. (2000), showing that the positive relationship between treatment outcomes and alliance was a direct relationship. Soto (2017) later reported updated evidence for the positive relationship between the therapeutic alliance and treatment outcomes. Soto conducted a meta-analysis of 23 studies examining the therapeutic alliance. These studies showed the therapeutic alliance to positively predict improved treatment outcomes ($r = 2.58$, 95% CI [.18, .33]. $p < .001$).

The conceptualisations of shared decision-making and the therapeutic alliance suggest that the two concepts share characteristics. Therefore, there are potentially actions within shared decision-making that could impact the therapeutic alliance. Given that the therapeutic alliance has been suggested to have a positive impact on psychotherapy outcomes, it is plausible that shared decision-making could have similar effects on psychotherapy outcomes. However, there are characteristics of shared decision-making not represented in the conceptualisations of the therapeutic alliance. As such, it is appropriate to examine any impact all characteristics of shared decision-making may have on psychotherapy outcomes.

Research aims

The research examining shared decision-making and synonymous concepts within psychotherapy indicate three directions for investigations within psychotherapies. The first direction is to determine the process by which shared

decisions occur within psychotherapy. This chapter has presented a definition of shared decision-making for psychotherapy adapted from healthcare conceptualisations and suggestions for best practice. This adapted definition expands on previous conceptualisations by explicitly including ongoing metatherapeutic communication, therapists' expertise, and whether a decision-making context is appropriate for discussing clinical evidence. This definition suggests how shared decision-making should occur in psychotherapy. However, this definition has not been empirically examined within practice. Therefore, the psychotherapy field could benefit from an investigation exploring how a therapist and client share decisions, how similar this process is to the adapted definition, and whether the characteristics of shared decision-making in healthcare are transferrable to a psychotherapy context.

The second direction is to understand clients' experiences of shared decision-making. This direction stems from practitioners' and patients' desires for more patient involvement in treatment decisions. There are also indications that patients would find taking part in shared decision-making to be helpful for their treatment. Developing this understanding of clients' experiences would enable comparisons between how much clients want to be involved in the decisions around their care, and how much they take part when given the opportunity. To do so, the present research should examine how clients retrospectively felt about taking part in a shared decision-making process, and whether being involved remained desirable afterwards. Furthermore, the accreditation and regulatory bodies for counselling and psychotherapy in the United Kingdom support the use of shared decision-making. Therefore, it would be useful to these fields to understand whether clients' experiences of shared decision-making are aligned with the ethical guidelines that encourage the approach.

The third direction is to establish any benefit shared decision-making might hold for clients or the psychotherapy process. Empirical findings have indicated shared decision-making interventions have a positive impact on satisfaction and perceived helpfulness within mental health and healthcare. Moreover, shared decision-making bares similarities to the therapeutic alliance, a concept associated with positive treatment outcomes. Therefore, it would be useful to both the research and practice of psychotherapy to determine whether there is a positive impact of shared decision-making on psychotherapy outcomes.

In summary, three research aims present themselves for an examination of shared decision-making in adult counselling and psychotherapies:

1. to identify the process by which therapists and clients share decisions in counselling and psychotherapy
2. to understand how clients experienced shared decision-making in counselling and psychotherapy
3. to evaluate the impact of shared decision-making in counselling and psychotherapy

Chapter two: Methodology

The pursuit of the three research aims will likely develop a comprehensive understanding of how shared decision-making can and does occur in psychotherapy, as well as any impact the approach might have on a client and their treatment. This thesis will pursue these aims using a multi-method approach that draws on a pragmatist ontology. This multi-method approach can cast a wider investigatory net than if each method was used in isolation. Doing so will build towards a holistic understanding of shared decision-making using both qualitative and quantitative methods that adopt different analytical lenses. Any findings obtained from these investigations can potentially contribute towards developing an evidence-based practice of shared decision-making in psychotherapy.

Outline and contributions of individual investigations

To pursue the three research aims of this thesis, four studies will investigate shared decision-making within counselling and psychotherapy. These consist of a systematic review of literature investigating shared decision-making in psychotherapy, a grounded theory investigation of clients' shared decision-making experiences, a conversation analysis of goal negotiations, and the development of multi-level models for psychotherapy outcomes. Further details of each method can be seen in their respective chapters.

Systematic review.

A systematic review will examine shared decision-making in counselling and psychotherapy research. This review will contribute towards the aim of understanding any relationship between shared decision-making and psychotherapy outcomes. The design and performing of this investigation will follow recommendations for the preferred reporting items for systematic reviews and meta-

analyses (PRISMA) (Liberati et al., 2009; Moher, Liberati, Tetzlaff, Altman, & PRISMA group, 2009). The use of this method will combine existing research findings and help determine if any conclusions can be drawn regarding the relationship between shared decision-making and psychotherapy outcomes. This review will also help determine the appropriateness of using the methods intended for investigations within subsequent chapters.

Interpersonal process recall and grounded theory.

A grounded theory approach using cued-recall interviews will explore shared decision-making in pluralistic therapy for depression. This investigation will help develop an understanding of how clients experience shared decision-making in psychotherapy. This analysis will also help identify the process by which therapists and clients make shared decisions. Pluralistic therapy clients will take part in semi-structured interviews and cued-recall, Interpersonal Process Recall interviews (IPR) (Bloom, 1954; Elliott, 1986; Kagan, 1973). Data from these interviews will be analysed using an adapted Grounded Theory analysis method for psychotherapy research (Rennie, Philips, & Quartaro, 1988). IPR interviewing will help clients recall their shared decision-making experiences and likely increase the accuracy of those clients' reports. The use of a grounded theory methodology alongside these interviews will assist with building a broad, comprehensive understanding of clients' experiences of shared decision-making.

Conversation analysis.

A Conversation Analysis will describe how decision negotiations occur between therapy dyads. This investigation will contribute to the aim of identifying the process by which therapists and clients share decisions. This analysis will use verbatim transcripts created from audio recordings of therapists' and clients'

decision-making talk. From these, detailed transcripts of therapists' and clients' speech and intonation will be created using Jefferson's (1984) transcription notation. A Conversation Analysis will then examine and describe the nuances and structure of the talk-in-interaction by the therapists and clients. This can include but is not limited to examining the conversational actions of each participant, the organisation of the sequences of their talk, and how each participant takes turns in that talk (Sacks, Schegloff, & Jefferson, 1974; Sacks, 1984, Schegloff, 2007). As such, a Conversation Analysis will offer a detailed description of individual episodes of decision negotiations between dyads, and what aspects of talk likely lead to a more shared decision-making process.

Multi-level modelling.

Multi-level models will be built for psychotherapy outcomes using shared decision-making and demographic variables. This study will include the design and testing of an observation scale for coding shared decision-making in psychotherapy. As such, this quantitative study will hold two aims. First, to evaluate any relationship between shared decision-making and psychotherapy outcomes. Second, to examine the feasibility of an observation scale for examining shared decision-making in psychotherapy.

The multi-level models will be developed using the Hox methodology (Hox, 2010; Hox & Maas, 2005). These models will be built for longitudinal client data of anxiety, depression, and goal progression, as well as therapist and client ratings of session effectiveness. Before building models, Fielding (2008) suggests framing the analysis from descriptive interpretations of the data. For example, inspecting the means of shared decision-making data against those of psychotherapy outcomes, as well as any correlations between the two. These inspections will help determine the

appropriateness of continuing with the construction of any models. Variable terms for shared decision-making and demographic data will then be independently tested within each model to see if they can predict outcomes and improve the fit of the model to the data. As such, this multi-level modelling analysis will offer an explorative, quantitative approach to understanding the relationship between shared decision-making and psychotherapy outcomes.

Analytical and methodological considerations

The present thesis adopts a pragmatist ontology. Pragmatism recognises a research problem or question as the focus for investigations and uses the most appropriate methods to provide an answer to that question (Patton, 1990; Creswell, 2003). As such, a mixed methodology approach will be used to investigate shared decision-making in psychotherapy. Hanson, Creswell, Clark, Petska, and Creswell (2005) advocate such mixed approaches to research as viable and useful within the field of counselling psychology. Moreover, this mixed methodology approach is aligned with pluralistic thinking. Pluralism refers to the belief in the existence of different kinds of things or ways to exist (Turner, 2010). Applying pluralistic thinking to psychological research would recognise the possibility of multiple answers to any one research question. For example, the process by which therapists and clients share decisions can be understood by both examining a client's observations of their assessment recordings or by observing a dyad's conversational actions. Frost et al. (2010) support a pluralistic approach to qualitative research. They suggest that using multiple qualitative methods to explore the same research question is preferable to using only a single method. Frost and colleagues propose that using a single method in isolation may not sufficiently access all information that qualitative data can offer.

The pragmatist ontology within the present thesis will draw on postpositivist and objectivist theoretical perspectives. The Grounded Theory approach taken here is aligned with an objectivist theoretical perspective. This perspective considers phenomena within a reality that exists independently of the research and that can be captured and understood, in part, using empirical methods (Ratner, 2002). This perspective coincides with Rennie et al.'s (1988) recommendations for building a grounded theory. Rennie et al. (1988) suggest that initial codes and categories should be descriptive and draw closely on participants' language and phrasing. In this way, a grounded theory would be initially influenced more by clients' reports than a researcher's interpretations. This approach contrasts with a constructivist grounded theory that builds codes and categories through a researcher's 'interpretations of the data, rather than emanating from them' (Charmaz, 2001, p. 6397).

The Conversation Analysis in chapter five is aligned with a realist theoretical perspective. This approach sees social phenomena as existing independently of our theories about them, with the reality of those phenomena as that which is observed by the senses rather than dependent on subjective interpretations (Phillips, 1987). As such, the conversation analysis will focus more on meanings of talk that can be directly observed. For example, descriptive understandings of how clients and therapists made decisions together, in situ.

The multi-level modelling analysis is aligned with a postpositivist theoretical perspective. This perspective is often associated with quantitative designs in counselling research, including observation and survey studies (Crotty, 1998; Ponterotto, 2005). This approach would see phenomena and its meanings as existing independently and externally of the participants' subjective evaluations (Bryman, 2012; Thornhill, 2012). Yet, a postpositivist approach acknowledges that a true

objective reality is hard to capture as variables exist that alter how a researcher sees that reality (Lincoln & Guba, 2000, Ponterotto, 2005). Therefore, the quantitative aspects of this thesis will recognise shared decision-making as measurable by psychometric tools.

The combination of methods and theoretical perspectives will cast a wider investigatory net than if each method was to be used in isolation. Yet, the methodological approach could be argued to be inconsistent due to the use of multiple approaches. However, each method can generate or highlight understandings of shared decision-making that other methods might not capture. For example, a Grounded Theory approach can offer a window into how the clients experienced shared decision-making during assessment. Whereas, a Conversation Analysis will magnify these shared decision-making experiences to examine them in detail and offer descriptions for how that process occurred. The quantitative analysis will then offer a broader understanding by objectively measuring the amount of shared decision-making occurring and showing how that relates to psychotherapy outcomes. In this way, the current pragmatist, multi-perspective, multi-method approach can develop a holistic understanding of shared decision-making in a psychotherapy context.

Self-reflexivity.

The researcher began the investigations in this thesis with a predisposed perspective of shared decision-making and the empowerment of psychotherapy clients as being a morally beneficial practice. However, the pragmatist ontology in this thesis helped to counter this predisposition as the researcher could select methods that would best fulfil the research aims. Doing so helped the researcher to select methods less likely to be influenced by their preference that may have

unintentionally added bias to the investigations. For example, the researcher used a method of grounded theory analysis that Rennie et al. (1988) suggests should start with creating categories that are more descriptive and influenced by client's reports, rather than by the researcher's interpretations. The researcher's positive predisposition towards shared decision-making was further accommodated for by the methodology of this thesis being aligned with pluralism. In doing so, the researcher could approach the individual research questions from a perspective that there could be many possible answers to those questions. In doing so, the researcher maintained an awareness that these answers could contrast with the researcher's prior perspectives and research knowledge.

Setting

All clients-participants took part in pluralistic therapy for depression at the Centre for Research in Social and Psychological Transformation's (CREST) Research Clinic, University of Roehampton. Pluralistic therapy is drawn from the concept that all therapeutic approaches can inform how to help a client pursue change, with no one right method that would be appropriate for all clients in all situations (Cooper & McLeod, 2007). As such, a defining principle of pluralistic therapy is that different methods within counselling and psychotherapy can be of use to different clients, at different times (Cooper & McLeod, 2011). Cooper and McLeod (2011) also emphasise the importance of dyads collaboratively identifying these methods.

Later, Cooper and Dryden (2016) present three pillars of the pluralistic approach to counselling and psychotherapy. These consist of pluralism across orientations, clients, and perspectives. Pluralism across orientations refers to a practitioner's openness to using different approaches to help clients in the different

ways they may become distressed. Pluralism across clients recognises the variety of clients that can enter into therapy and the importance of offering a bespoke treatment in line with this diversity. Pluralism across perspectives advocates that a practitioner and client may have different perspectives and preferences for progressing therapy. As such, a pluralistic practitioner should involve their client in shared decision-making, for example, when negotiating therapy goals or tasks.

McLeod and Cooper (2012) present a treatment protocol for pluralistic therapy for depression. This protocol was adapted to for a maximum of 24 sessions, with two points for therapy reviews at sessions four and 10. At these points, dyads should review how they have been working together and any changes they could make to their work together. This protocol recognises four phases to therapy.

First, a therapist should work to build a collaborative relationship and elicit a client's story. Part of this includes informing a client with about what would be involved in the therapy. Therapists should also open discussions around a client's social world and aspects of that client's life story relevant they feel could be relevant to the therapy. Dyads should also discuss a client's goals and expectations for therapy, as well as how these goals might be accomplished. Therapists should also work to elicit a client's preferences regarding arrangements for therapy and how the best way of working for the dyad. In doing so, a dyad should discuss what resources and strengths both parties can bring to the therapy.

Second, a dyad should establish a formulation or plan of work for the therapy. It is likely that dyads can co-construct a case formulation within initial assessment and treatment sessions. Such a formulation should be presented tentatively and recorded externally. At this point, a therapist should propose their

ideas regarding a client's difficulties and what the dyad could do in therapy that might help with those difficulties.

Third, dyads in pluralistic therapy should engage in activities designed to facilitate change towards a client's goals. Here, a shift occurs from dyads discussing what might be helpful to working towards change. At this point, the treatment protocol emphasises the importance of a therapist following up on a client's ideas for tasks. Yet, pluralistic therapy is not entirely client-led, and therapists should make suggestions for tasks they feel could help, or if a client offers no suggestion. As dyads perform these tasks throughout treatment, a therapist should encourage discussions around whether to continue, modify, or change tasks. Throughout, a therapist should be open to working with a range of methods within their skills and expertise.

Last, the final sessions of treatment should centre around bringing the therapy to an end and both reviewing and consolidating a client's progress. Here, dyads can discuss what a client has learned, what they have achieved through tasks, and any progress they have made towards their goals. At this point, a therapist and client can discuss the potential for relapse and strategies that client can use to help in the event of such relapse.

Participants

The sample consisted of 14 adult clients. Six of these were included in the Conversation Analysis investigation. The IPR interviews and grounded theory analysis drew on the first 14 clients entering the clinic from January 2016 onwards. The multi-level modelling analysis drew on the same client sample and their data from assessment to end-point. The conversation analysis drew on subset of the 14

clients, with greater detail available in chapter five. This analysis used session recordings created between January 2016 and September 2017

All clients were recruited in collaboration with the University of Roehampton's Well-being Team. The Well-being Team referred clients they felt could benefit from a longer-term intervention beyond the four to eight-week interventions that were available. Accepted clients were required to meet Research Clinic eligibility criteria: being over the age of 18; having an aspect of their life they would like to improve; and a score of 10 or more on the Patient Health Questionnaire-9 (Kroenke & Spitzer, 2002) at the point of assessment. Referrals were ineligible for treatment if they belonged to a University of Roehampton course within the department of Psychology. Referrals were also ineligible if they held severe, enduring mental health difficulties that might interfere with treatment.

The 14 clients were undergraduate or post-graduate students of the University of Roehampton. The clients had a mean age of 21.8 ($n = 11$) and ranged from 18 to 34 years. A majority of clients were female (71.4%, $n = 10$). In terms of ethnicity, clients were predominantly white, British (78.6%, $n = 11$), followed by other, Mixed (7.1%, $n = 1$), and unknown (14.3%, $n = 2$). Three clients reported living with a disability (21.4%). A minority of clients were taking anti-depressant medication at the time of assessment (35.7%, $n = 5$). Clients completed an average of 14.5 weekly sessions, out of a maximum of 24. Clients were not expected to attend a minimum number of sessions. Over half of clients had planned treatment endings (57.1%, $n = 8$). Six clients ended treatment due to self-discontinuation of treatment, non-attendance, or situational factors such as a location change.

Eight therapists worked alongside the 14 clients. Therapists were male (25%, $n = 2$) and female (75%, $n = 6$). Three therapists worked with a single client, four

therapists worked alongside two clients, and one therapist worked with three clients. Therapists were qualified counsellors, psychotherapists, or counselling psychologists, as well as experienced trainees performing a professional Doctorate in Counselling Psychology. All therapists received training in pluralistic therapy.

Data collection

The University of Roehampton Ethics Committee granted data collection approval under application reference number PSYC16/229 and took place within CREST Research Clinic under application PSYC15/169.

An information sheet prior to assessment advised clients of the treatment and research expectations within the Research Clinic (see Appendix A1). This included details of session recording and data usage. Therapists reiterated this information at assessment and checked clients' understanding. Clients able to provide informed consent did so by signing a physical form before any data collection began (see Appendix A2). Signed forms were stored in a locked filing cabinet at the University of Roehampton.

The information sheet advised clients of their right to withdraw from the research component of their treatment. Clients could withdraw from the research without specifying a reason. These clients could continue their treatment. This sheet informed clients that any data collected before withdrawal might still be used. However, clients could request their data be removed up until the point of analysis. Therapists reiterated withdrawal information to clients during assessment.

The information sheet and therapists informed clients that assessment and treatment sessions would be audio recorded. Therapists familiarised clients with the recorder at assessment and advised that it could be turned off at any time. Clients did not have to provide a justification for turning off the recorder. All audio data was

recorded using secure, University of Roehampton devices. Audio data was stored on an external, encrypted storage device inside a locked filing cabinet at the University of Roehampton. Audio data was stored separately to personal client data and in accordance with the University's data storage and protection policies.

Audio recordings of pluralistic therapy sessions began in January 2016. These recordings were then used immediately for IPR interviewing. Creation of verbatim transcripts for assessment sessions and interviews began in February 2016. These transcripts were then used for grounded theory analysis and conversation analysis case selection. Further details of intended use for client transcripts are available in the method sections of individual chapters.

Clients completed psychometric measures of anxiety, depression, and goal attainment at the start of each session, including their assessment. Both clients and therapists completed indicators of session effectiveness at the end of sessions, excluding assessments. Together, all measures took approximately 10 minutes to complete and can be seen in appendix B. Psychometric properties for these measures are available in chapter six.

All data were collected concurrently for all studies. However, the Grounded Theory analysis began before the Conversation Analysis. The Conversation Analysis was completed before developing multi-level models for psychotherapy outcomes. Adhering to this order limited any methodological crossover or comparisons when examining data through different analytical lenses.

Software

All clients completed measures on encrypted handheld devices using the online software Pragmatic Tracker (www.pragmatictracker.com). The creators of this software trained and supported the researcher in its use, who in turn trained

therapists. Therapists in turn instructed clients in the use of the software. NVivo 10 was used for qualitative data management and coding, and SPSS (22) and MLWIN (3.01) was used for quantitative data management and analysis. Training was received for all three software packages.

Structure of investigations

This chapter has demonstrated the benefit in using a mixed methods approach to develop an understanding of shared decision-making in psychotherapy. The structure of the investigations in this thesis will help build towards this understanding. Chapter three will contain a systematic review investigating findings from existing research examining shared decision-making. Chapters four and five will then advance this understanding through inductive qualitative methods. Chapter four will feature a Grounded Theory approach guided by four research questions. These research questions will likely offer insights into all three research aims of this thesis. Chapter five will contain a Conversation Analysis to explore how therapists and clients make decisions in detail. This chapter will likely provide an in-depth understanding of the shared decision-making process. Next, chapter six will use any findings from both qualitative chapters to inform the design of a scale to measure shared decision-making in psychotherapy. Data obtained using this scale will be tested within multi-level models for psychotherapy outcomes. Any findings from the development of these models will then be compared to any quantitative indications of the impact of shared decision-making from chapter three and any qualitative indications from chapters four and five. Last, chapter seven will discuss each individual study with regards to the three research aims. The intention for this final chapter is to arrive at recommendations for shared decision-making practice in

counselling and psychotherapy, as well as directions for expanding understandings of the approach.

Chapter three: The prevalence and impact of shared decision-making in psychological therapies

This chapter will review the research literature examining shared decision-making within counselling and psychotherapy contexts. In doing so, it could offer indications as to how much shared decision-making is occurring in psychotherapy practice, and if the approach has a relationship with psychotherapy outcomes. Such a review is useful for determining the appropriateness of intended methods for investigations in subsequent chapters. For example, whether an explorative multi-level modelling approach is appropriate for evaluating the relationship between shared decision-making and psychotherapy outcomes, or whether there is sufficient evidence to direct the development of models.

Prevalence of shared decision-making within healthcare and psychotherapy

Before examining any relationship between shared decision-making and psychotherapy outcomes, it would be appropriate to determine how much the approach is occurring in practice. Makoul and Clayman (2006) showed that there is no agreed model for how to implement shared decision-making in healthcare. This has implications for how consistent the practice is in helping professions, including psychotherapy. For example, that practitioners could differ in how they perform shared decision-making. Moreover, there are no formal frameworks for the practice of shared decision-making in psychotherapy. As such, there is the potential for inconsistency in how therapists might implement a shared decision-making approach in their practice. The field of psychotherapy could therefore benefit from determining whether shared decision-making is occurring in practice, and to what extent.

The extent of shared decision-making occurring in practice could differ depending on who is reporting on that process. For example, general practitioners who believed they used shared decision-making in their consultations were not seen to be doing so (Stevenson, Barry, Britten, Barber, & Bradley, 2000). The interactions between these practitioners and patients did not include all of Charles et al.'s (1997) characteristics for shared decision-making. Charles, Whelan, Gafni, Wilan, and Farrell (2003) later showed that a minority of a physician sample defined shared decision-making by an information exchange or division of labour only. A minority also stated that they would prolong preference discussions only if their and their patient's preferences were incongruent. Such physicians saw congruent preferences as agreement, rather than further exploring those preference with their patients. Ford, Schofield, and Hope (2006) later observed 212 general practice consultations and showed that decisions were generally practitioner led. Yet, some practitioners in this sample were more likely than others to work with their patient's preferences. Together, these findings suggest that practitioners', patients', and researchers' perspectives can differ regarding how shared a decision-making process was in practice.

Practitioners' and clients' understandings within an interaction can also differ in psychotherapy contexts. Rennie (1998) proposes that a practitioner and client can have different perceptions of talk and meaning in psychotherapy. For example, Angus and Rennie (1988) examined practitioners' and clients' use of metaphors in treatment sessions. At times, a practitioner and client would continue an interaction thinking they understood each other, despite conveying different meanings. These findings imply a practitioner and client could hold different perceptions during psychotherapy decision-making. A review of research examining shared decision-

making could bring together both client and therapist perspectives of how the approach occurs in practice.

Research examining shared decision-making and psychotherapy interactions suggests two justifications for examining the prevalence of shared decision-making in psychotherapy. First, there is no agreed framework for shared decision-making in psychotherapy, and therefore the possibility for variability in how therapists think they should practice the approach. Second, shared decision-making likely occurs less in practice than the amount advocated, with the potential for practitioners and patients to hold different perceptions of psychotherapy interactions.

However, proponents of shared decision-making have established integrative definitions and models for the approach in healthcare and mental health (Coulter & Collins, 2011; Makoul & Clayman, 2006). Such updates to the conceptualisation of shared decision-making have assisted in comparing studies across approaches. This has helped build towards a clearer understanding of any impact of shared decision-making can have within helping professions.

Impact of shared decision-making in mental health services

Research from mental health contexts indicates benefits to using shared decision-making. However, shared decision-making in mental health can also include treatments excluding psychotherapy, such as psychopharmacological treatment. Therefore, such findings should be used to offer an indication only as to what relationship shared decision-making might hold with outcomes in psychotherapy.

Duncan, Best, and Hagen (2010) present a narrative synthesis of two investigations reported in three papers (Hamann, et al., 2006; Hamann et al., 2007; Loh et al., 2007). These studies contained 518 patients in German acute inpatient and

community primary care settings. The findings show patients in a shared decision-making intervention reported greater patient treatment satisfaction, in comparison to a control group (Loh et al., 2007). Loh et al. report a similar outcome for greater practitioner facilitation of patients' participation. Duncan et al. present findings from Hamann et al. (2006) showing that intervention patients' knowledge of their condition was greater at discharge, compared to a control group. Hamann et al. (2006) also show practitioners were more satisfied with patients' treatment in the intervention group than the control groups. Both Hamann et al. (2006) and Loh et al. (2007) show consultations times did not increase when using a shared decision-making intervention. However, Duncan et al. (2010) suggest the evidence did not allow for definitive conclusions about the impact of shared decision-making on treatment.

Later evidence showed shared decision-making to have a positive impact on mental health treatment. Lindhiem, Bennett, Trentacosta, and McLear (2014) reported their meta-analysis of 32 clinical trials that contained active choice conditions or interventions. These interventions included shared decision-making interventions or other interventions that accommodated for a client's preference. The meta-analysis contained psychotherapy data, although this was analysed alongside healthcare and mental health data. Clients involved in shared decision-making practices were more likely than those not involved to experience higher treatment satisfaction (Cohen's $d = 0.34$; $p < .001$) and increased completion rates (Odds ratio = 1.37; Cohen's $d = 0.17$; $p < .001$). Lindhiem et al. also report better clinical outcomes for clients involved in shared decision-making, compared to those not involved (Cohen's $d = 0.15$; $p < .0001$). The latter findings offer new evidence suggesting clinical benefits to practising shared decision-making.

Meta-analyses of research examining clients' preferences in psychotherapy supports Duncan et al.'s (2010) and Lindhiem et al.'s (2014) indications of a positive relationship between shared decision-making and treatment outcomes. Swift and Callahan (2009) reviewed research examining the effects of accommodating for client preferences in psychotherapy. They reviewed 26 studies containing 2,356 clients. Clients matched to their preferred treatment were around half as likely to drop-out than those not matched; with a medium effect size (Random effects model 0.58, 95% CI [0.10, 0.18], $p < .05$). Clients matched to their preferred treatment had more chance of showing greater improvement (58%) than those unmatched (42%), with a small effect size (Random effects model = 0.15, 95% CI [0.09, 0.21], $p < .001$). Later, Swift, Callahan, Cooper, and Parkin (2018) provided an updated review of studies examining preference accommodation in psychotherapy. They included 53 studies that examined the impact of accommodating for a clients' preferences on treatment outcomes and dropout. Swift et al. demonstrated across 51 studies ($n = 16,269$) that there was a small, significant effect size on treatment outcomes in favour of preference accommodation in psychotherapy (Cohen's $d = 0.28$, 95% CI [0.17, 0.38], $p < .001$). They also showed across 28 studies ($n = 3,237$) that clients who were not matched to their preferred treatment conditions were 1.79 times more likely to dropout than those that were matched, with a significant, small effect size (Odds ratio = 1.79, 95% CI [1.44, 2.22], $p < .001$). Together, the findings of these reviews imply that accommodating for client preferences within shared decision-making can positively impact a client's treatment.

Further evidence supports Swift and Callahan (2009) and Swift et al. (2018), demonstrating collaborative communication within mental health to have a positive impact on patient treatment adherence. Thompson and McCabe (2012) reviewed

research examining practitioner-patient communication in mental health contexts to determine any impact on treatment adherence. They present a narrative synthesis of 23 studies. Thompson and McCabe conclude that shared decision-making and collaborative communication is associated with more favourable treatment adherence. Bauer et al. (2014) later support Thompson and McCabe's (2012) findings in their examination of anti-depressant medication adherence. They show a lack of patient-perceived shared decision-making to be associated with antidepressant non-adherence (Risk ratio = 2.42, $p < .05$) and early non-persistence (Risk ratio = 1.34, $p < .01$).

Evidence from healthcare and mental health has demonstrated shared decision-making to have a positive impact on patient satisfaction, treatment adherence, and clinical outcomes. Moreover, research examining preference accommodation and collaborative communication in psychotherapy has shown that approaches similar to shared decision-making can have a positive impact on treatment outcomes and client dropout. Therefore, it would be useful to examine if such positive impact is also found for shared decision-making within a psychotherapy context. In doing so, any findings could be compared to those indicating accommodation of client preferences as having a positive effect on treatment.

Research aims

The following study aimed to review research examining shared decision-making within the context of psychotherapy. In doing so, this chapter will update the findings from research in mental health and psychotherapy demonstrating that similar approaches to shared decision-making can be beneficial for clients and their treatment (Duncan et al., 2010, Lindhiem et al., 2014; Swift & Callahan, 2009; Swift

et al., 2018; Thompson & McCabe, 2012). Moreover, determining the extent that shared decision-making takes place in psychotherapy would aid in evaluating how widespread any impact of the approach likely is. This chapter will evaluate the prevalence and impact of shared decision-making through the following research questions:

1. To what extent does shared decision-making take place within the psychotherapy?
2. What is the relationship between shared decision-making and outcomes in the psychotherapy?

Method

Protocol and design

The researcher developed a review protocol, finalised in December 2015. The protocol and subsequent review adhere to PRISMA guidelines (Moher, Liberati, Tetzlaff, Altman, & PRISMA group, 2009; Liberati, et al., 2009). Findings are presented in a narrative synthesis due to insufficient data and a heterogeneity of study methodologies. This review differentiates between qualitative and quantitative findings, where appropriate.

Eligibility criteria of studies

Types of studies.

Studies were required to be performed within a context of psychotherapy. This includes any context where a client takes part in psychotherapy or counselling with a psychiatrist, psychologist, or another mental health providers. Studies reporting psychopharmacological treatments only were excluded.

Eligible studies were to contain sufficient descriptions to determine shared decision-making was examined. This description could explicitly refer to shared

decision-making or to similar terminology describing characteristics of the approach (Charles et al., 1997;1999; Towle & Godolphin, 1999; Elwyn et al., 2000; Makoul & Clayman, 2006; Coulter and Collins, 2011). This similar terminology should describe practitioners and clients collaborating on decisions. However, the protocol excluded studies focusing on general collaborative practices only. For example, studies were ineligible if examining the therapeutic alliance only, as the alliance does not include all characteristics comprising shared decision-making (Chapter 1).

Both quantitative and qualitative studies were eligible if they were of a systematic nature or used a systematic method. For example, systematic designs consisting of: case studies; cohort studies; longitudinal studies; observational studies; randomised trials; and qualitative studies, including of autoethnographic studies. Randomised trials were exclusively eligible for the examination of the relationship between shared decision-making and outcomes. These latter eligibility criteria ensured an un-biased comparison of findings across studies.

Types of participants.

Eligible studies contained participants over the age of 18 who were, or had previously, taken part in psychotherapy. Studies with any or no comparator conditions could contribute to the question of the prevalence of shared decision-making. These studies need to have occurred in a naturalistic setting. Studies with at least one comparator condition were eligible to contribute to the question of the relationship between shared decision-making and outcomes.

Types of outcomes.

Both quantitative or qualitative outcomes could contribute to the question of the relationship between shared decision-making and outcomes. The protocol categorised outcomes under three umbrella terms. Clinical outcomes included

indicators for: psychological distress; psychological well-being; quality of life; and characteristics of a mental condition, disorder, or illness. Health management outcomes included: independent living; adherence to scheduled sessions; the practice of self-management methods; ability to contribute within a community; and reduction in the use of health services and medication. Psychotherapy specific outcomes included but were not limited to: perceived helpfulness of therapy; perceived shared decision-making; goal progress; and satisfaction with the treatment.

Types of publication.

Eligible studies were those published after the year 1990. This date is when calls for change to clinical decision-making began to take hold in healthcare (Brock & Wartman, 1990; Gray, Doan, & Church, 1990; Duncan et al., 2010). Studies could be peer-reviewed journals or deemed to hold an in-press status for a peer-reviewed journal at the time of the literature search. Studies could also be: books or book chapters; dissertations; organisational or government reports; or unpublished data accessed during the literature search. Included studies were written in or contained adequate information in English.

Information sources

The researcher searched the following electronic databases: APA databases (PsycARTICLES, PsycBOOKS, PsycINFO, PsycNET); Cochrane Library; EBSCOhost EJS (Academic Search Premier); EthOS, British Library, ISI Web of Science / Core Collection; PubMed (inclusive of PubMed Central and MEDLINE; National Library of Medicine); and Psychoanalytic Electronic Publishing (PEP). The Journal of Participatory Medicine was hand searched.

The researcher searched reference lists in review articles by the following authors: Charles et al. (1997); Charles et al. (1990); Coulter and Collins (2011),

Duncan et al. (2010); Da Silva (2012); and Ahmad et al. (2014). Reference lists were also searched in the following books and book chapters: Cooper, Dryden, Martin, and Papayianni (2015); and Rennie (1998). These articles were chosen as they contained conceptual developments for shared decision-making in healthcare and psychotherapy.

Search

The researcher proposed search terms drawn from the shared decision-making literature within healthcare and mental health. These were refined into a testable search strategy. Each search contained three terms. Two terms described the target concept and were searched within title or abstract fields, and a third term described the target context that was searched across all fields. For example, the term ‘shared’ could be paired with ‘decision#making’ and searched in title or abstract fields, supported by a contextual term such as ‘psych*’ or ‘therap*’ within all fields. The search strategy was adapted and tested for PsycINFO. The researcher and a second colleague used these search results to refine the search strategy. Searches were conducted for studies published between January 1990 and December 2015, with the final search on 14th December 2015. Appendix C contains the refined search strategy, adapted for PubMed.

Study selection

The researcher used abstracts and titles to screen all search results, with a third colleague assessing a sample of these results ($n = 1,600$). The researcher and second screener compared eligible studies and those for removal. Next, the researcher obtained full texts of retained articles. Both parties independently assessed full texts, comparing selections for exclusion and inclusion before agreeing on a final selection. All reasons for exclusions of full-texts were recorded.

Data collection process and items

The researcher developed a data extraction sheet that was scrutinised by a fourth colleague. This sheet contained items to capture: study characteristics; details of the shared decision-making approach; data relevant to the prevalence of shared decision-making; types of variables; outcome measures; findings not covered by variable or outcome measures; and risk of bias. The researcher extracted all data.

Risk of bias in individual studies

Studies were assessed for risk of bias using Cochrane Collaboration's tool at both outcome and study level (Higgins et al., 2011). Using Cochrane Collaboration's tool follows PRISMA recommendations for use over scale and checklist methods (Liberati et al., 2009; Moher et al., 2009). The Cochrane tool is a standardised approach for reviewers to assess bias in randomised control trials. Therefore, sections of the tool may not be appropriate for other types of design including case studies or cross-sectional and survey studies.

Findings

Study selection

Searches identified a total pool of 20,606 articles. This pool included articles from: electronic bibliographic databases ($k = 19,919$); key chapters and articles ($k = 678$); and hand searches ($k = 9$). The researcher used abstracts and titles to remove duplicate articles ($k = 4,476$) and ineligible studies ($k = 16,028$). Common exclusion reasons include studies not taking place in a psychotherapy context or containing child and young person samples only.

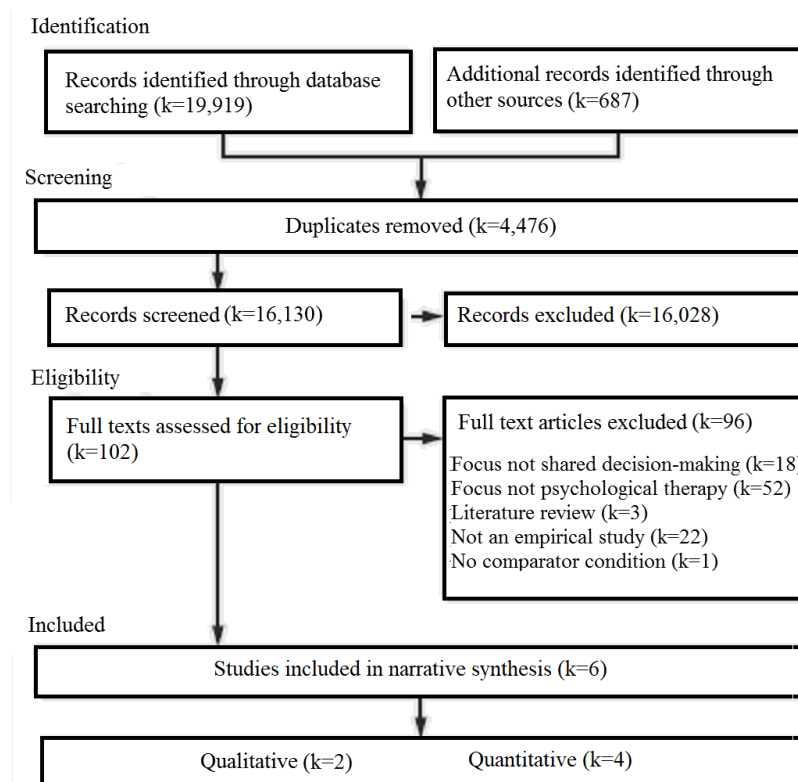
Next, the researcher and second screener independently scrutinised all full texts ($k = 102$). We removed studies that: were in a setting other than psychotherapy ($k = 52$); did not have a sufficient description to determine shared decision-making

as the research focus ($k = 18$); were not an empirical study ($k = 22$); were a literature review ($k = 3$); or did not contain comparator conditions ($k = 1$). We reached a consensus on all full texts, with six eligible for inclusion in the review. Four authors of eligible studies were contacted for file-drawer studies. No further studies met the eligibility criteria. A breakdown of the full data collection and screening process can be seen in Figure 1.

Cohen's Kappa was used to assess inter-rater reliability of independent full-text decisions, as suggested by Hallgren's (2012) for two coders of nominal data. The researcher's and second screener's decisions had moderate agreement (Cohen's $k = .56$, 95% CI [0.46, 0.67], $p < .001$) (Landis & Koch, 1977).

Figure 1

The flow of information through the stages of the systematic review



Study characteristics

Modalities of psychotherapy.

Included studies reported differing theoretical orientations and types of treatment ($k = 5$). Orientations within survey-based included: humanistic or humanistic-existential; gestalt; psychodynamic; eclectic; cognitive-behavioural; systemic; bio-energetic; or unspecified (Barr et al., 2016; Williams et al., 2016). Practitioners used cognitive-behavioural treatments within interview-based and conversational analytic designs (Ekberg & LeCouteur, 2014; Osei-Bonsu et al., 2016). Trial-based designs contained cognitive-behavioural approaches (Mott, Stanley, Street, Grady, & Teng, 2014) and unspecified approaches (Mckay, 2011).

Shared decision-making interventions.

One study reported a metacommunication intervention (Mckay, 2011). This intervention consisted of familiarising clients with the importance of metacommunication; ways to practice metacommunication; and demonstrations and roleplays of metacommunication. Clients were asked for their preferences for metacommunication and encouraged to share these as therapy progressed. Clients took part in the intervention prior to any psychotherapy treatment.

Mott et al. (2014) reported a shared decision-making intervention in post-traumatic stress disorder treatment. The intervention was designed to assist practitioners and clients in sharing a treatment selection decision as part of a 30-minute meeting, prior to psychotherapy. The intervention included a 12-page decision-aid. This decision aid provided an overview of effectiveness for five treatment options and invited clients to ask for additional information. The aid also directed clients to alternative treatments. Furthermore, the practitioners in the intervention received a shared decision-making manual. This manual contained

example scripts and prompts for discussing treatment options with clients. The manual drew on Elywn et al.'s (2012) competencies for performing shared decision-making. These competencies consist of three stages of talk between a practitioner and client. First, is *choice talk* to outline the decision to be made and affirm to the patient that they have a choice in that decision. Second, is *option talk* whereby a practitioner presents options to a client, describes any potential harm or benefits of those options, and checks the client's knowledge and preferences. Last, is *decision talk* that focuses the discussion on eliciting informed preferences and moving towards a decision in light of these. Practitioners should offer clients an opportunity to review the final decision at a later time.

Methods and participants.

Total participants ($N = 15,674$) included psychotherapy clients ($n = 15,649$; $k = 5$) and practitioners ($n = 25$, $k = 2$). Quantitative studies contained a majority of clients ($n = 15,630$, $k = 4$) and qualitative studies contained all practitioners ($n = 25$, $k = 2$). The available data for treatment status shows a majority of participants to be in psychotherapy at the time of study participation (81.6%, $n = 959/1175$, $k = 3$).

Data were available from six settings, consisting of: community-based and public practice ($k = 2$); specialist clinics ($k = 4$); and university services ($k = 2$). One study examined shared decision-making in 184 public health services in England and Wales (Williams et al., 2016). Two studies occurred in United States-based healthcare organisations (Barr et al., 2016; Mott et al., 2014). The remaining three studies took place in Adelaide, South Australia (Ekberg & LeCouteur, 2014), Michigan, USA (Mckay, 2011), and Northeast USA (Osei-Bonsu et al., 2016). Summaries of each study's design and relationships with the research questions are displayed in Table 1.

Table 1

All studies included in the final review

Included study	Design and methodology	Location	Participants and setting	Prevalence	Outcomes
Barr et al. (2016)	Quantitative, online parallel cross-sectional surveys.	United States	742 individuals currently receiving, awaiting, or had previously received treatment for depression. 172 clinicians who had recently treated individuals with depression.	Naturalistic setting. There was an 18.5% probability of consumers reporting a top shared decision-making score from their most recent practitioner encounter.	
Ekberg & LeCouteur (2014)	Qualitative, conversation analysis.	South Australia	A corpus of 20 cognitive behavioural therapy sessions involving nine practitioners and 19 clients receiving treatment for depression.	The potential for a discrepancy between practitioners' intentions to include patients in decisions and leading discussions in practice.	
Mckay (2011)	Quantitative, randomised control trial with a treatment-as-usual comparator group	United States	44 clients seeking counselling at university counselling services. 20 clients were randomised to a metacommunication intervention group and 24 to the treatment-as-usual group.		Controlled study. No significant difference between the two groups at week six for: family and academic distress, improvement of presenting issues, depression, and general or social anxiety. No significant difference for the amount of sessions attended at week 12.

Included study	Design and methodology	Location	Participants and setting	Prevalence	Outcomes
					Significant difference for arousal at week six.
Mott et al. (2014)	Quantitative, randomised control pilot with a treatment-as-usual comparator group	United States	27 military veterans who had served at least one deployment tour attending a Veterans Health Association clinic specialising in post-traumatic stress disorder treatment.		Controlled study. All intervention participants who responded post-treatment were satisfied with the intervention. Intervention participants attended more sessions than the control group overall but missed a greater amount of sessions than the control group, on average.
Osei-Bonsu et al. (2016)	Qualitative, content analysis, semi-structured interviews	Northeast United States	16 licensed psychologists and social workers from two Veteran's Association medical centres with at least 5 years of experience in their discipline.	The potential for a discrepancy between organisational guidelines for shared decision-making and the amount occurring in practice.	
Williams et al. (2016)	Quantitative, cross-sectional survey	United Kingdom	14,587 respondents from 220 United Kingdom national health services.	Naturalistic setting. A majority of clients with at least one preference report being offered sufficient choice for time of appointments, venue, language, and type of treatment.	

Shared decision-making approach.

Three studies used pre-existing conceptualisations of shared decision-making from the medical field. Barr et al. (2016) drew on Charles et al. (1997; 1999). Mott et al. (2014) drew on Elwyn et al. (2012) and Osei-Bonsu et al. (2016) drew on Elwyn et al. (2010).

Outcomes.

Two controlled studies measured outcomes during and after treatment (Mckay, 2011; Mott et al., 2014). McKay also measured outcomes before treatment. One study measured clinical outcomes, consisting of: anxiety and depression, academic distress, body image issues, family distress, and substance misuse (Mckay, 2011). Both studies measured the health management outcome of client attendance (Mckay, 2011; Mott et al., 2014). Both studies measured psychotherapy specific outcomes. McKay measured arousal, control, hostility, sharing, and working alliance (Mckay, 2011). Mott et al. (2014) measured clients' satisfaction with the shared decision-making intervention.

Risk of bias within studies

Studies were judged for their risk of bias using the Cochrane Collaboration's risk of bias tool (Higgins et al., 2011). This tool helps reviewers to appraise a study as having low, high, or unclear risk of bias across domains of bias.

Selection bias.

Two studies contained low risk for selection bias by using pre-packaged randomised envelopes (Mckay, 2011; Mott et al., 2014). McKay (2011) uses separate randomisation schemes for each practitioner. Three studies contained high risk, allocating participants by preference, depression severity, or time of treatment (Barr et al., 2016; Osei-Bonsu et al., 2016; Williams et al., 2016).

Blinding of participants, personnel, and outcome assessors.

One study contained high risk for performance and detection bias (Mckay, 2011). One study contains a low risk (Mott et al., 2014).

Incomplete outcome data.

All studies contained low risk for attrition bias.

Selective outcome reporting.

Two studies contained low risk for reporting bias (Mckay, 2011; Mott et al., 2014). Four studies contain unclear risk, with no protocol or insufficient information available (Barr et al., 2016; Ekberg & LeCouteur, 2014; Osei-Bonsu et al., 2016; Williams et al., 2016).

Prevalence of shared decision-making

Two studies examined the prevalence of shared decision-making in naturalistic settings (Barr et al., 2016; Williams et al., 2016).

Barr et al. (2016) reported patients' scores from the CollaboRATE shared decision-making measure. A majority of patients reported below-maximum scores in their most recent practitioner encounter (82%, $n = 637/781$) (Barr et al., 2016). Patients reported a maximum score when working with a therapist (18.5%, 95% CI [13.4-23.6%]) less than those working with psychiatrists (24.5, 95% CI [18.7-30.3%]), but more than patients working with primary care physicians (14.8%, 95% CI [8.9-20.7%]).

Williams et al. (2016) examined patients' reports of their treatment preferences. These patients confirmed having at least one preference for psychotherapy. A minority of patients felt that they had not been offered sufficient choice (36.7%, $n = 4,600$, 95% CI [35.8-37.5]) (2016). The remainder felt they were offered adequate choice. These patients likely took part in shared decision-making as

they had expressed a preference, been presented with options, and worked towards a decision based on those preferences (Charles 1997;1999; Coulter & Collins, 2011). A majority of clients felt they were offered sufficient choice for: time of appointments (82.4%, $n = 8,639/10,476$); choice of venue (70.2%, $n = 5,282/7,524$); language (62.73%, $n = 643/1,025$); and type of treatment (66.93%, $n = 4,981/7,442$). However, a majority of consumers thought they were not offered adequate choice for practitioner gender (58.4%, $n = 2,483/4,252$).

The discrepancy between guidelines or intentions, and practice.

Two studies demonstrated a discrepancy between shared decision-making practice and guidelines or intentions to implement the approach (Ekberg & LeCouteur, 2014; Osei-Bonsu et al., 2016).

Ekberg and LeCouteur (2014) described practitioners' *co-implication* of clients in the decision-making process. Here, co-implication refers to a practitioner inviting a client to actively take part in formulating plans for behavioural change. Practitioners would begin discussions by inviting a client to make suggestions. At times, these practitioners would then lead negotiations by using anticipatory completions; completing the client's speech turns during vague or weak responses. Ekberg and LeCouteur reported clients in these instances were resisting the practitioner's proposals for behavioural change. Ekberg and LeCouteur liken this resistance to other decision-making instances in their corpus that contained only practitioners' proposals for behavioural change.

Osei-Bonsu et al. (2016) reported practitioners' adherence to organisational guidelines for shared decision-making in post-traumatic stress disorder treatment selections. Some practitioners adhered to these guidelines in practice. Others reported not fully engaging the patient and prejudging the patient's readiness or

appropriateness for treatment methods. These providers prejudged readiness by patients' displays of a want or need to discuss trauma.

The relationship between shared decision-making and outcomes

All clinical outcome findings are from McKay's (2011) controlled study and can be seen in table 2. McKay reported no effect sizes due to a small sample reducing the statistical power of the study.

McKay (2011) and Mott et al. (2014) offer findings for the health management outcome of client attendance. McKay (2011) reported client attendance in a shared decision-making intervention condition was greater at session three, in comparison to a control group ($t(27) = 1.89, p = .07$). This difference was not maintained by week six or 12 ($t(18) = 0.65, p = .53$; $t(31) = 0.53, p = .6$). Mott et al. (2014) descriptively reported attendance for nine clients who initiated psychotherapy. A greater number of clients from the shared decision-making intervention group took part in nine or more treatment sessions ($n = 4$), in comparison to the control group ($n = 1$). The remaining three clients in the control group took part in one to eight sessions. However, clients in the control group who had scheduled at least one psychotherapy visit missed fewer appointments than the intervention group, on average ($M = 1.3, SD = 0.9, n = 7$; $M = 1.9, SD = 1.9, n = 7$). However, Mott et al. (2014) report that their small sample size prevented significance testing across the study conditions.

Mott et al. (2014) reported data for the psychotherapy specific outcome of clients' satisfaction with the shared decision-making intervention. Five clients took part in post-treatment interviews. These clients belonged to the shared decision-making intervention group. All five clients report feeling satisfied with the intervention they received.

Table 2

*Differences in outcomes between Mckay's (2011) shared decision-making
intervention and control group*

Outcome	Session one		Session two		Session three		Session six		Session twelve	
	<i>t</i>	Df	<i>t</i>	df	<i>t</i>	df	<i>t</i>	df	<i>t</i>	df
Clinical outcomes										
Therapist rated-improvement									0.12	29
Academic distress					-0.66	27	0.59	18		
Eating or body image					0.64	27	-0.60	18		
Family distress					-0.17	27	-0.1	18		
Substance use					0.63	27	0.99	18		
Depression					1.89	27	0.65	18		
Social anxiety					-0.41	27	-.025	18		
Generalised anxiety					2.58*	27	0.87	18		
Health management outcomes										
Attendance					1.89	27	0.65	18	0.53	31
Secondary outcomes for psychotherapy										
Arousal			-1.91	34	-2.43*	29	-2.33*	20		
Experience of control										
Hostility	1.28	41			1.79	27	1.56	18		
Sharing	3.31*	41			2.14*	32				
	*									
Working alliance (C)	-0.58	42			0.72	31	0.88	20		
Working alliance (Th)	-1.91	42			0.47	31	-0.31	20		

Note. * = Significant at 0.05; **Significant at 0.01.

Discussion

Summary of evidence

Two studies from naturalistic settings suggest shared decision-making is occurring in psychotherapy practice within the United Kingdom and the United States. However, it is not occurring in all instances of decision-making. Two further studies showed the amount of shared decision-making occurring in practice can differ from that intended by practitioners or suggested by organisational guidelines.

Two studies showed mixed evidence for any relationship between shared decision-making and outcomes. One controlled study showed a potential positive impact of shared decision-making on depression and anxiety treatment. However, this impact did not continue past the third session of treatment. One study implied shared-decision making has little impact on clients' attendance. Whereas, another study showed clients who shared treatment decisions attended more sessions than a control group. Findings across two studies indicated shared decision-making to have a positive relationship with psychotherapy outcomes. These consisted of arousal reduction, hostility reduction, practitioners' working alliance ratings; and intervention satisfaction.

Prevalence of shared decision-making

Williams et al. (2016) showed that shared decision-making is occurring in practice within the United Kingdom. These findings were drawn from a large sample of 14,587 clients across 184 public health services. The prevalence of shared decision-making demonstrated by these findings supports national survey data. The Care Quality Commission (2018) present the 2017 survey findings ($N = 72,778$). Patients reported receiving greater quality of information and having greater quality of communication with practitioners in comparison to previous years. A majority of

patients felt they were sufficiently involved in their care decisions (56%); an overall increase from 50% in 2009 ($N = 67,580$). These patients responded ‘Yes, definitely’ to the item ‘Were you involved as much as you wanted to be in decisions about your care and treatment?’.

William’s et al.’s (2016) findings are also aligned with recent public health policy changes. Government policy pushed to ensure shared decision-making occurs in United Kingdom public health services (Department of Health, 2005). Later, Elwyn (2010) stated that United Kingdom healthcare services had adequately begun to integrate shared decision-making practice. Coulter (2010) supports Elwyn (2010), writing that the United Kingdom national health services were offering patients more choices of providers or locations. However, Coulter (2010) recommends greater change towards increased patient involvement in treatment decisions. Subsequent healthcare law changes pushed for the accommodation of individuals’ reasonable requirements in the care they receive (Health and Social Care Act, 2012). The Department of Health (2015) later amended the national health service constitution to show patients have a right to receive care reflective of their preferences (Department of Health, 2015). Recently, the National Health Service and The National Institute for Health and Care Excellence have collaborated to promote shared decision-making as the norm in United Kingdom healthcare (Leng, Clark, Brian, & Patridge, 2017). Promotion included raising awareness of shared decision-making and raising patient expectations for how active a role they can expect to take their treatment decisions. The collaboration also sought to increase the availability of decision aids. Together, these policy changes show an increasing priority for practicing shared decision-making in United Kingdom health services. Moreover, Leng et al. (2017) demonstrate an active commitment to ensuring shared decision-

making occurs in practice and that patients are aware of it. Despite these advances in the use of shared decision-making, a minority of clients within Williams et al.'s (2016) felt they were not offered enough choice after expressing a preference. As such, shared decision-making practice could be examined to determine why a minority of clients felt their available choices were lacking, despite the.

Barr et al. (2016) showed that shared decision-making may not be occurring in all practice within the United States. They reported that under a quarter of participants experienced a high level of shared decision-making in their most recent practitioner encounter. Barr et al. reported no scores for participants scoring less than the maximum on the CollaboRATE measure. This limits the conclusions that can be drawn for the remainder of the participants' experiences of shared decision-making. Nevertheless, these findings would have growing implications as the evidence base for shared decision-making's relationship with outcomes grows. For example, a lack of shared decision-making practice should be scrutinised if the approach is confirmed as beneficial.

Two included studies showed a discrepancy between the practice of shared decision-making and the guidelines or intentions for implementing the approach. Ekberg and LeCouteur (2014) showed instances of practitioners leading negotiations during intended collaborative decision-making. Osei-Bonsu et al. (2016) offered similar instances, although reports practitioners using their professional judgement to lead decisions. Practitioners in both studies intended or were given guidance to practice collaborative decision-making. These findings could be attributed to the lack of an agreed shared decision-making definition or standardised practice of the approach within adult psychotherapy. Therefore, further evidence is needed from

practice settings to determine how shared decision-making should occur within psychotherapy.

Impact of shared decision-making

This review supports the conclusions of Duncan et al. (2010) by demonstrating a lack of a positive relationship between shared decision-making and clinical outcomes. However, the current findings are also in contrast to the positive impact demonstrated by Lindhiem et al. (2014). The findings in this review were drawn from a single controlled study with a small sample size. As such, it would be useful to gain further evidence to enable firmer conclusions about any impact of shared decision-making on clinical outcomes. Researchers would do well to use McKay's (2011) findings as a starting point for comparisons.

This review reports limited evidence for the relationship between shared decision-making and health management outcomes. One study suggested a lack of a relationship, whereas another suggests mixed findings inclusive of a positive relationship with attendance. Therefore, the evidence base would benefit from further research into shared decision-making's relationship with health management outcomes. This further research should examine: independent living, adherence to scheduled sessions, the practice of self-management methods, ability to contribute within a community or society, health service use, and medication use.

The present review reports findings that indicate a positive relationship between shared decision-making and psychotherapy specific outcomes. Mott et al. (2014) indicated clients were satisfied with their experience of shared decision-making. Furthermore, McKay (2011) showed shared decision-making to be associated with reduced client arousal, reduced client hostility, and increased practitioner working alliance ratings. Both clients' reduced hostility and

practitioners' increased working alliance ratings were reported at session one of treatment. McKay also presented reduced client arousal at sessions two, three, and six. These findings imply shared decision-making can have both an immediate and enduring positive effect.

Duncan et al. (2010) reported the research examining shared decision-making in mental health lacked measurement of secondary outcomes. These outcomes were: satisfaction with the decision, the experience of the interaction, quality of life, knowledge of the condition, intent to change health behaviour, and involvement of family members or carers in decisions. This review shows that the psychotherapy field still lacks any measurement of clients' experiences of shared decision-making, as well as the involvement of family or carers. Nor could this review identify findings regarding client intent to change behaviour. Future research should fulfil these measurement gaps in the research literature.

Limitations limited evidence

Two small-scale, controlled studies were eligible for determining the relationship between shared decision-making and outcomes. Both McKay (2011) and Mott et al. (2014) indicated a lack of adequate power for the whole duration of their investigations. McKay's (2011) findings were based on a small number of participants across an intervention group ($n = 20$) and control group ($n = 24$). Half of the clients terminated treatment by session six ($n = 22$), split evenly between each experimental condition. Similarly, Mott et al. (2014) reported findings from a small-scale pilot study ($n = 27$). However, a limited amount of the total clients initiated psychotherapy ($n = 4$), with under half in the intervention group ($n = 4$). Therefore, Mott et al. chose to present their data descriptively without statistical significance testing of differences between study conditions. Given these low sample sizes by the

end of the studies, there is an increased risk of either incorrectly concluding a positive impact or lack of impact of the approach on outcomes (Columb & Atkinson, 2015). Therefore, the present review can present only potential indications of any impact of shared decision-making on clinical, health management, or psychotherapy specific outcomes.

The number of studies eligible for inclusion in this review limited any qualitative or quantitative data synthesis. However, the six included studies demonstrate a rising body of shared decision-making evidence within psychotherapy. To illustrate, Duncan et al. (2010) identified only two studies across three papers specific to mental health. Later, Thompson and McCabe (2012) identified a total of 23 eligible studies within mental health. This study identifies six eligible studies for psychotherapy alone. Yet, searches yielded more studies outside of the eligibility criteria or within the wider field of mental health.

Implications for practice and research

Together, the studies included in the present review suggest practitioners can lead the decision-making process more than their intentions or organisational guidelines might suggest. As such, practitioners should maintain an awareness of previously identified characteristics of shared decision-making when implementing the approach. For example, practitioners could draw on the adapted definition proposed by the current researcher (Chapter 1).

The findings of Duncan et al. (2010) imply clients' experiences of shared decision-making were not measured within a psychotherapy context. This review shows client experiences remain unmeasured. As such, future researchers could perform in-depth qualitative analyses of clients' and practitioners' experiences of shared decision-making. Such examinations could provide the basis of an

understanding for any impact of shared decision-making on health management and psychotherapy specific outcomes.

Future researchers should conduct controlled trials examining shared decision-making, with subsequent meta-analyses. These trials should examine the relationship between shared decision-making and clinical outcomes. These future studies would be comparable to McKay (2011) and Mott et al. (2014) to help draw firmer conclusions regarding any positive impact of shared decision-making on beneficial treatment.

Conclusion

The present systematic review brings together findings from six studies in the first review of literature examining shared decision-making within adult psychotherapy. This review suggests that not all decisions are shared within the United Kingdom and the United States psychotherapy services. Moreover, practitioners can potentially lead the decision-making process more than they intend. This review shows indications of shared decision-making having a positive relationship with client satisfaction, reduced client arousal, reduced client hostility, and greater therapist ratings of the working alliance. This review found mixed findings for client attendance. It would be useful to the field to further explore the impact of shared decision-making on outcomes through controlled quantitative trials and in-depth qualitative analyses.

Chapter four: Clients' experiences of shared decision-making in pluralistic therapy for depression

Building on chapter three, this chapter will take an inductive approach to developing an understanding of clients' experiences of shared decision-making in a psychotherapy context. In doing so, this chapter will address the lack of research examining shared decision-making in psychotherapy. Given this lack, it is appropriate to review evidence across helping professions for indications of any impact a shared decision-making process could have on psychotherapy treatment. Subsequently, it would also be appropriate to examine how a shared decision-making process can occur and how practitioners can involve their patients or clients within that process.

Chapter three showed that clients' experiences of shared decision-making have not been examined in a psychotherapy context. However, research in healthcare and mental health can inform an understanding of how clients might experience the approach in psychotherapy. For example, Duncan et al. (2010) reviewed studies examining shared decision-making interventions in mental health contexts. They reported one study that showed a shared decision-making intervention to have a positive impact on patient treatment satisfaction, and another study did not. They also conclude that no studies measured patients' satisfaction with decisions, nor patients' experiences of their interactions with their practitioner during shared decision-making. Later, Brom et al. (2017) reported that patients in an outpatient healthcare context felt they were involved in their treatment decision-making and were satisfied with it.

Research examining shared decision-making in healthcare and mental suggests the approach can be a positive, satisfying experience. These findings

coupled with the lack of research examining shared decision-making in psychotherapy suggests a benefit to examining clients' experiences of the approach in psychotherapy. This examination would help to develop an understanding of whether shared decision-making can be a positive experience for psychotherapy clients, as it is for healthcare patients.

Leadership in treatment decision-making

Research examining shared decision-making in psychotherapy shows that the leadership and influence within that process is not always shared. For example, the findings of Ekberg and LeCouteur (2014) and Osei-Bonsu et al. (2018) demonstrate that a discrepancy can exist between the amount of shared decision-making intended by practitioners and the amount performed in practice. Moreover, Charles et al. (1997) proposed that both patient and practitioner can be more or less involved in the process of treatment decision-making in healthcare. Similarly, Cooper and McLeod (2011) proposed that decision-making in psychotherapy exists on a continuum from client-led to therapist-led, with entirely shared as a mid-point. Therefore, there is the potential for decision-making styles to crossover as the interaction becomes more or less shared. Quirk, Chaplin, Lelliot, and Seal (2012) showed support for this continuum. Using conversation analysis, they reported that few decisions within psychiatric outpatient consultations were truly shared and could contain more or less pressure from a therapist. They demonstrated shared decisions could contain more pressure from a therapist for a client to select a specific decision. Quirk et al. (2012) also showed shared decision-making could include less pressure from a therapist and more encouragement from the therapist for a patient to lead.

The research examining leadership within shared decision-making shows that attempts to practice the approach can result in a decision-making process that has

equal leadership between participants. However, there can also be instances of intended shared decision-making that contain pressure from practitioners or encouragement for clients to take more of a lead, as well as instances that may not be shared at all. Therefore, it would be useful to examine whether intended shared decision-making practice is experienced as shared by the clients taking part in that practice. This examination would also increase the validity of any subsequent analysis as it would include instances of decision-making that clients did experience as shared.

Facilitating client involvement in shared decisions

The healthcare field has developed tools to help patients take part in their treatment decisions. Such tools can help inform how a client's involvement could be facilitated in shared decision-making within psychotherapy. The Ottawa Personal Decision Guide facilitates shared decision-making for health and social care decisions with both individuals and families (Feenstra, 2012; O'Connor, 1995; O'Connor et al., 1998). This decision aid elicits a patient's information and support needs for practitioners to then modify the shared decision-making process. To elicit these needs, the aid asks patients how much involvement and what role they would like in the decision-making. Patients are then asked which decision information they are most confident in their understanding of, which is most important to them, and where they would like extra support. They are also asked whose opinion is most important to them. Additional support could include a practitioner providing extra information, although the aid also asks patients what support they feel would most benefit them. Feenstra et al. (2015) showed that the parents of families using this decision-aid saw it as a feasible and helpful tool for selecting healthcare decisions with their children and practitioners. The Ottawa Personal Decision Guide and

Feenstra et al.'s (2015) findings suggest practitioners can facilitate shared decision-making by accommodating for a patient's role preferences and information needs, as well as offering bespoke support for those needs.

Healthcare research has also shown that practitioners can facilitate patient involvement in shared decision-making through the types of responses they give and the questions they ask. Henselmans, Van Laarhoven, Van der Vloodt, De Haes, and Smets (2017) examined patients' experiences of shared decision-making within a palliative care setting. They coded 60 audio recordings of consultations between 13 oncologists and their 41 patients living with cancer. Henselmans et al. reported 122 instances of patients offering at least one preference during talk. Of these, 50 instances (41%) contained two or more utterances of preference talk. When practitioners responded to patients' preference utterances with probing question, patients responded in 92% ($n = 35/38$) of instances with more preference talk. For example, one patient offers "I don't want to participate in studies anymore", to which their practitioner replies "May I ask why not?" (Henselmans et al., 2017, p. 630). Similarly, patients offered further preference information in a majority of instances when practitioners responded with checking questions (93%, $n = 13/14$), by reflecting or rephrasing preference utterances (71%, $n = 12/17$), or by showing empathy (100%, $n = 2/2$).

Together, these studies suggest that a practitioner can facilitate their patient's involvement in shared decision-making. For example, by eliciting a patient's preferences for roles within the decision-making process and the importance they place on opinions or information. Therapists can then encourage further preference information by responding to a client's preference talk using probing questions, checking questions, reflecting a client's preference talk, and showing empathy. As

such, it would be useful to examine what actions a therapist or client can use to facilitate a shared decision-making process in a psychotherapy interaction.

Research aims

Research examining shared decision-making across helping professions has offered findings showing the approach could have a positive impact on client's perceptions of the decision-making processes in psychotherapy. Moreover, shared decision-making processes can have equal or unbalanced leadership between parties and can include actions to facilitate clients' involvement. Therefore, it would be useful to develop an understanding of clients' experiences of the approach within a psychotherapy context. To develop this understanding, this chapter aimed to build a comprehensive account of client-reported experiences, guided by the following four research questions:

1. How did clients experience the shared decision-making process?
2. What was the impact of the shared decision-making process on the client?
3. If the decision-making process was shared, who was leading that process?
4. What elements of the interaction during the decision-making process were experienced as helpful by clients for facilitating shared decision-making?

Method

Design

This chapter used a qualitative research design to examine clients' experiences of shared decision-making in pluralistic therapy for depression. Data were collected using a cued recall interview method known as Interpersonal Process

Recall (IPR) (Bloom, 1954; Elliott, 1986; Kagan, 1973). Supplementary, semi-structured interviews occurred following these IPR interviews. Data was collected in using a Grounded Theory approach (Glaser, 1978; Glaser & Strauss, 1967).

Transcripts were then created from audio recordings of both interview styles and examined using a Grounded Theory analysis adapted for psychotherapy research (Rennie et al., 1988).

Participants

Participants were the first 14 adult clients referred to take part in pluralistic therapy for depression at the Centre for Research in Social and Psychological Transformation's (CREST) Research Clinic, University of Roehampton. Eight therapists worked with these clients. All clients took part in a pluralistic assessment before interview. Further details of clients, therapists, and pluralistic therapy can be seen in chapter three.

Interpersonal Process Recall

This investigation used a cued-recall interview method to help clients remember and report their experiences. The method for examining interactions used cued recall has been labelled as Interpersonal Process Recall (Bloom, 1954; Elliott, 1986; Kagan, 1973). This method uses audio or video recordings of an interviewee's previous interactions as cues to help them generate rich observations of their past experiences. Using IPR can offer a more accurate recollection of events than compared to unassisted recollections of only those moments immediately accessible to memory (Elliott, 1986; Larsen, Flesaker, & Stege, 2008).

IPR has been demonstrated to be an appropriate method for examining psychotherapy and clinical interactions. For example, Elliott (1986) proposes IPR for investigating subtle and covert aspects of the therapy process. Angus and Rennie

(1988) and Larsen et al. (2008) later show IPR to be a feasible method for investigating client and therapist interactions. Similarly, Saba et al. (2006) showed the effectiveness of the IPR method for investigating clinical shared decision-making. They combine transcripts from IPR interviews with a formal coding tool to confirm the presence or absence of shared decision-making. Saba et al. (2006) indicated the presence of shared decision-making in half of coded decisions ($n = 125$). As such, they confirm that IPR interview method could be used to identify shared decisions.

Moreover, the IPR method has been shown to hold acceptable psychometric properties during investigations in a psychotherapy context. Elliott, Barker, Caskey and Pistrang (1982) used ratings of helpfulness and empathy during IPR interviews to show internal reliability across ratings ($\alpha = .5$ to $.66$). Others have indicated adequate convergent validity through positive correlations between therapists' and clients' ratings of helpfulness (Caskey, Barker, & Elliott, 1984; Elliott, 1985). However, Elliott (1986) suggests the IPR method is associated with much variability in responses.

Conducting IPR investigations during psychotherapy can be beneficial to the client and their therapeutic work. Kagan (1973) and colleagues promoted the use of IPR from the observation that stimulating recall of participants could: "enable people to understand themselves better, to recognise their impact on others, to realize the impact of others on them" (p. 2). Rennie (1990) later reported that IPR interviewees felt the method helped them gain an enriched view of their recorded therapy sessions (Rennie, 1990). Similarly, Larson et al. (2008) found that practitioner interviewees gained a clearer view of the recorded therapeutic work. These practitioners felt they

were able to use their new views in later sessions. Together, these findings suggest the benefit of conducting IPR research within ongoing treatment.

Materials and interview schedules

Decision-making audio units.

The researcher reviewed audio recordings of clients' assessment sessions to select units of audio for interview playback. Elliott (1985) suggests this approach to audio unit selection is more appropriate for examining specific events, rather than asking interviewees to evaluate all available audio. Units were selected if they contained decision relevant talk. For example, containing talk about therapy aims, goals, preferences, methods, or therapeutic contracts that occurs during a pluralistic assessment (McLeod & Cooper, 2012). Furthermore, Bernard and Goodyear (1992) suggest that audio units should be interpersonally weighted. That is, containing exchanges of talk between both therapist and client, rather than talk from a single speaker only.

IPR question and prompt sheet.

During interview, questions and prompts were used following audio units and clients' observations. Larsen et al. (2008) encourage researchers to focus their questioning on past moments, rather than clients' thoughts and feelings in the present. This past focus helps to deemphasise content and encourage clients to maintain an observer focus (Larsen et al., 2008). The IPR prompt sheet can be seen in appendix D.

The IPR prompt sheet was informed by existing psychotherapy and IPR literature (Cashwell, 1994; Elliott, 1986; Larsen et al., 2008; McLeod & Cooper, 2012; Saba et al., 2006). For example, the prompt to query whether the client wanted more or less direction was informed by the therapist directiveness subscale of the

Cooper-Norcross Inventory of Preferences (Cooper & Norcross, 2016). Examples of prompt questions that were asked include:

- What was your role in the interaction?
- To what extent do you feel the interaction was led by you, the therapist or did you work together?
- What were your impressions of the therapist's actions at that point?
- What were your feelings at that point?

An observing, process focus was maintained through using sentence stems such as 'As you reflect on that moment in therapy...' and 'taking a step back from that moment...'. Silence, summaries, or clarification questions were also used to encourage clients to expand on their previous talk.

Review point interview schedule.

Supplementary interviews were conducted after a client's IPR interview.

These were semi-structured interviews that did not use cued recall. All semi-structured interviews occurred following a client's therapy review at session four.

This interview re-examined assessment decisions, and any emerging decisions from the first four treatment sessions. These decisions included those made at assessment and review using the Goals Form (Cooper, 2015) and the Cooper-Norcross Inventory of Preferences (Cooper & Norcross, 2016). Questioning also included subtle decisions such as participation in extra-therapeutic activities or discussion topics within treatment sessions. The review point interview schedule can be seen in appendix E.

Procedure

Clients took part in IPR interviews immediately before their first treatment session, following assessment. This timing ensured therapists could immediately

address any emotional distress their clients may have experienced during interview. Elliott (1986) suggests holding IPR interviews within 48 hours of an interaction to ensure the most vivid recall. However, this duration was extended to seven days to minimise client inconvenience and emotional fatigue. All therapists were aware that their clients were participating in research interviews before treatment sessions. The researcher conducted all interviews.

IPR interviews lasted 70 to 90 minutes, although one interview was shorter and lasted 50 minutes. Interviews began with an explanation of IPR, the purpose of the interview, and what would be expected of clients in taking part. Next, clients had the opportunity to practice the IPR method with an example audio unit. Larsen et al. (2008) suggest this opportunity to practice the method is important for establishing expectations, roles, and a safe environment for interviewees. A client would then play and pause audio units on a handheld device, offering commentary on the recording. Questions and prompts were used throughout the interviews in response to a client, or if the client did not produce an observation.

Eleven clients took part in semi-structured interviews immediately before their fifth treatment session. These interviews lasted between 30 and 58 minutes. Three clients were unable to attend these interviews due to unplanned treatment endings ($n = 2$) or limited client availability ($n = 1$). Data from both interviews were analysed together, except when a distinction between the two-time points was meaningful. For example, when clients reported an aspect of their experience in one interview only.

Analytical method

Transcripts from both IPR and review point interviews were analysed using a grounded theory approach adapted for psychotherapy research (Rennie et al., 1988).

Research examining client perspectives in psychotherapy has previously used a grounded theory method. Rennie et al. (1988) showed the applicability of the method for examining client reports gained from IPR interviews. Similarly, MacFarlane, Anderson, and McClintock (2017) used the adapted method to successfully investigate clients' experiences and perceptions of empathy within psychotherapy. These studies show the appropriateness of using IPR to examine clients' psychotherapy experiences in the present study.

Rennie et al.'s (1988) method is informed by Glaser and Strauss's (1967) steps for performing a grounded theory analysis, consisting of: data collection; open categorising; concurrently and systematically collecting data; establishing categories; memoing; and identifying emerging patterns to determine a core category. As such, Rennie et al. (1988) offer guidelines for performing the adapted grounded theory approach. First, analysts should code sections of transcripts into units of meaning. This contrasts to the traditional grounded theory approach that analyses transcripts line by line. These meaning units are then organised into early stage categories. Early categories are often descriptive rather than abstract and are derived directly from participants' speech. Analysts should make ongoing comparisons between new meaning units and previous categories. Rennie and colleagues propose analysts memo any potential or developing relationships between categories, as analysis progresses.

Once incoming data no longer adds new meaning, Rennie et al. (1988) suggest analysts focus on the relationships between categories. This process began to occur for the present study after 11 IPR and review point interviews. Next, analysts should make judgements about central categories. These judgements include whether to collapse or remove categories with few connections, or whether to merge

categories. For example, the present analysis identified a category containing coded meaning units for a decision-making process led by a single party only. Therefore, this category was removed as it did not contribute to the emerging structure of shared decision-making experiences. Rennie et al. (1988) suggest analysts may find it useful at this stage to examine why meaning units could have been coded into multiple categories.

Rennie et al. (1988) then suggest analysts move towards developing a central, core category that is most related to the other categories. This core category is often abstract but defined by those categories comprising it. The core category should evolve throughout analysis as new information is coded and relationships examined. Glaser (1978) proposes that should two or more core categories emerge, analysts should try to determine if one category can subsume the other. Analysts use this final core category and its constituent parts to present a comprehensive understanding of the target research phenomena.

Rennie et al. (1988) suggest their adapted grounded theory approach is useful for understanding clients' experiences in a manner uncontaminated by previously known theory or bias from the researcher. However, the researcher had prior knowledge of shared decision-making and pluralistic therapy theory. It was therefore important to ensure early stages of coding and categories were descriptive and closely drew on clients' speech. To maintain this descriptive accuracy, two co-researchers audited meaning units and early stage categories after seven IPR interviews.

Rennie et al.'s (1988) process for coding meaning units also helped maintain a descriptive accuracy and limit interpretative bias from previous knowledge. Rennie et al. suggest for analysts at early stages to reduce participants speech to descriptive

summaries, before providing single line summaries and a category label. For example, the following client's response could be coded as the therapist recurrently checking client understanding of the decision and technical information, as suggested by Elwyn et al.'s (2000) competencies:

I suppose this just shows that its useful to check what I meant. Like I said there is some point to going through the form to make sure that they know that I answered it correctly and how I wanted it to be answered.
(A591-592)

However, this client's response this was instead reduced to the single line summary of 'being checked with was useful for therapist's clarity and client's meaning'. This was then labelled this response with the categories of 'being checked with' and 'meaning behind preferences'. As such, the coding includes the meaning behind the client's preferences, where this would not have been captured if coded using the researcher's pre-existing knowledge of Elwyn et al. (2000).

Analysis

Decision-making leadership

Clients evaluated the decisions made by themselves and their therapists in their assessments and first four treatment sessions as shared, therapist-led, and client-led. A majority of clients' evaluations were coded as shared, whether led equally or more by themselves or their therapist ($n = 193$). However, there were also instances of decision-making led by a single party that did not contribute to the emerging structure of shared decision-making experiences. This was due to the present analysis aiming to examine instances of shared decision-making, who was leading that process, and what helped facilitate that process. As such, the present analysis

focuses on those decisions evaluated as shared, shared, but more therapist-led, and shared, but more client-led. Table 3 shows the number of times each type of decision-making was coded, across clients.

Table 3

Amount of coded evaluations from clients across different decision-making leadership styles.

	Clients	Codes
Therapist-led	12	37
Shared, but more therapist-led	13	83
Shared equally by therapist and client	12	96
Shared, but more client-led	4	14
Client-led	10	40

Categories and components

The researcher coded 819 meaning units across transcripts of 14 clients' experiences of shared decision-making. These meaning units were used to build a framework of categories and components that contributed to a single core category. Categories and components included meaning units from both the IPR and review point interviews. The exception was the category *Daunting for clients to be asked to take part in the decision-making process* as this contained clients' observations from IPR interviews only.

Categories and their components do not contain exclusive groups of clients or audio units. For example, a client could have perceived the decision-making process within separate audio units from the same session as shared, shared and led more by themselves, or shared and led more by their therapist.

Perceptions of sharedness.

All clients evaluated at least one instance of a decision discussion they felt was shared. Clients produced these evaluations upon listening to audio units during their interpersonal-process recall interviews, as well as during review point interviews. However, these reports show that clients saw instances of shared decision-making that were led more by themselves or their therapist.

Shared, but more therapist-led decision-making.

Thirteen clients reported instances of shared decision-making that they felt were more therapist-led: “[Therapist] obviously, a little bit more... but again is almost a shared thing” (L95-99). Clients in these instances felt there was a marginal difference between how much they or their therapist were leading the process: “because it’s a collaborative effort I have to put in my 49 percent” (F421-422). Despite clients reporting these instances as more therapist-led, they saw themselves as active in contributing to the decision discussions: “Not passive. I think I would have been passive if [Therapist] hadn’t have asked” (A343-344).

Shared leadership over the decision-making process.

Twelve clients saw instances of shared decision-making within their assessment and review point sessions that were led equally between themselves and their therapist: “I think it was definitely shared” (A200). These clients felt this perception was due to seeing both party’s actions as two people working together towards a decision, rather than separately: “Sort of cooperative. We worked on it together. Rather than it being just me” (I932). Five of these clients felt that decisions made from this process were mutually agreed upon: “discussing things enough to make sure that we came to a conclusion together” (G637).

Shared, but more client-led decision-making.

Four clients recognised instances of decision-making that were shared but led more by themselves. These clients still saw themselves as working together with therapists: “It was mostly me, but then a joint effort in the sense that we sort of both worked towards thinking of that as a natural goal” (C273-275). Clients felt their perspective on these instances was due to observing therapists actively contributing suggestions to decision discussions: “I felt it was probably more me but equal kind of. I don’t know. [Therapist] put things forward and then let me take it from there” (G115-116).

Therapists supporting clients to become more active in the decision-making process.

Clients felt that their therapists encouraged and supported their activity in decision discussions, and that this was helpful for facilitating a shared decision-making process. All clients reported this encouragement and support in at least one audio unit. These clients observed this support occurring across four therapist actions: creating space for the client to offer input; directly referring to clients or inviting them to have input; helping clients to frame suggestions during difficulty; and acknowledging and reassuring the client after they made suggestions, encouraging further contributions. The number of codes for each category component across clients can be seen in table four.

Helping clients to articulate suggestions and wants.

Fourteen clients’ felt their therapists helped them articulate their suggestions and wants in decision discussions. All clients reported these actions from their therapist in least one audio segment. These clients felt their therapists guided them through a process that helped them frame their suggestions, goals, and wants. This guidance often occurred when clients were uncertain how to define their treatment

wants or goals: “It was obvious that I wanted to feel better, so that’s not really a useful answer either so erm, yeah [Therapist] helped me to say what it is practically that I want to change” (A205-207). Eight clients felt this guiding extended to their therapist offering suggestions that were grounded in the client’s speech: “[Therapist] didn’t lead me but [Therapist] gave me a reference point that I could then say “right, what can I do with that” (I260-261).

Explicitly inviting clients to contribute.

Thirteen clients saw their therapist as inviting them to make contributions to decision discussions. These invitations were more explicit than therapists providing opportunities for a client to contribute to discussion or helping that client to articulate a suggestion. Clients felt their therapists facilitated their involvement through offering encouraging prompts: “nudged me into writing it a bit, more than outrightly saying ‘we should do this’” (L376). One client felt their therapist’s invitation to take part in decisions discussion was more helpful for their involvement than instructing them to take part: “I feel like [Therapist] in that situation like, egged me on to make a decision instead of telling me to make a decision. Because I could have just said ‘no’” (H265-266). In addition to verbal invitations, seven clients felt that completing formal feedback tools such as the Cooper-Norcross Inventory of Preferences helped them contribute to decision discussions: “Writing it down and then talking about it was much easier than actually having to directly say” (D698-699).

Acknowledging clients’ expressed preferences and suggestions.

Clients reported instances of their therapists acknowledging their contributions and reassuring them of the appropriateness of making those contributions: “[Therapist] kind of reassured me that like, it’s okay to make

decisions like that and to know what you want out of counselling. So [Therapist] helped me to be able to express my opinions and things” (H110-111). This acknowledgement and reassurance occurred whether a client’s contribution came from the therapist helping to articulate a suggestion, an explicit invitation, or a therapist-provided opportunity for input. Seven of these clients saw this acknowledgement as useful for facilitating shared decision discussions and for encouraging participation in future discussions: “[Therapist] didn’t like sort of slam down the overall- [Therapist] was like ‘no, that’s good. But now how do we get there in the progress- the progression’” (D119-120).

Providing opportunities for clients’ input.

Clients reported that their therapists provided opportunities for them to have input in the decision-making process. Three clients felt such opportunities provided them with the space to be a part of the decision-making process: “I wasn’t being pushed in any direction... Allowed a space for me to come to more of a decision I guess, than if [Therapist] had been more decisive and I felt more less able” (G644-648). Other clients felt this space was helpful for contributing more of their ideas to decision discussions: “But then [Therapist] would let me expand where I needed to and prompted further into some things and let me go on in others” (I12-14). Therapists providing such opportunities for client input were more implicit invitations than helping clients to articulate suggestions or explicitly inviting a client to contribute.

Both parties presenting and recognising expert knowledge.

Thirteen clients experienced both themselves and their therapist as sharing specialist knowledge with each other. Clients saw this sharing as helpful for facilitating a shared decision-making process as each party became aware of clients’

preferences, wants, and circumstances, as well as the therapist's expertise and professional recommendations.

Therapists contributing specialist psychotherapy knowledge.

Thirteen clients saw their therapist as sharing specialist psychotherapy knowledge. These clients found their therapist's suggestions to be helpful for progressing decision-making. For example, one client felt they did not have the appropriate knowledge to make suggestions in decision discussions:

I may be the expert, but I don't know how to apply that knowledge, [Therapist] does. So, it makes sense to just kind of let [Therapist] suggest stuff and me occasionally suggest stuff when I've got a better understanding of what we're talking about. (F364-366).

Eleven clients also saw instances where their therapists provided explanations and examples of how in-session and extratherapeutic methods could be used: "explaining the use of the [support] then means I can get more out of that, and so I think that's why" (C189-190).

Clients demonstrating a willingness to consider the therapist's expert knowledge.

Thirteen clients saw themselves as demonstrating a willingness to consider their therapist's suggestions: "I will take into consideration anything [Therapist] says and anything [Therapist] proposes. Because they're the therapist and the therapist and is the person with the information" (G417-418). The same client felt they wanted to be open to their therapist's ideas and suggestions and wanted their therapist to be aware of that openness: "I think I would like [Therapist] be aware that I am open to their suggestions. I don't want to come across as a person who's shooting down

anything they've said or any ideas that [Therapist] has" (G630-632). Another client felt that in moving towards shared decision, they wanted to include their therapist's ideas about how to pursue a therapy goal:

I think you need the input because... the way you want to cont- proceed might not necessarily be the best way. Or if you got some other feedback or some guidance then you can bounce off each other and work something out. (N353-357).

Clients sharing specialist knowledge about themselves and their preferences.

Twelve clients saw themselves as sharing specialist information about themselves that their therapist did not hold. This included clients' wants, preferences, and details about their circumstances they felt were important to the decision discussion: "telling [Therapist] my experience, how I felt, my likes and interests. And [Therapist] going from that" (E515). For one client, this included how a potential decision could impact their family and friends: "Because obviously like, I know the people involved so I know what will and won't work" (I1027-1028).

Clients felt recognised as an individual and accommodated for by their therapist.

Thirteen clients felt they were recognised as an individual and accommodated for by their therapist within the shared decision-making process. Three components contributed to this category. First, that clients felt the decisions rising from the share decision-making process were relevant and useful to them and what they wanted to achieve in therapy. Second, that clients felt the final decisions and their therapist' actions accommodated for their preferences and wants. Last, that clients felt listen to an understood by their therapist within decision-making.

Decisions were relevant to and useful for clients.

Eleven clients felt that decisions resulting from a shared decision-making process were meaningful and relevant to themselves and their treatment: “I think it’s relevant, I mean obviously [Therapist] didn’t pull it out of nowhere” (J543). Two clients were asked at review point if this relevance remained, and both agreed it had. Five clients felt these decisions were important for what they wanted to achieve in therapy: “Because like at the very beginning I was just starting to realise that that was a major issue for me” (C383-384). Other clients felt these decisions made their therapy wants feel achievable: “They’re quite- quite achievable. And this is a good idea.” (A740). This feeling of importance was also true for clients that decided not to work with goals: “so leaving that open ended was probably quite important for me” (G542-543).

Clients, their preferences, and their wants were accommodated for.

Eight clients reported that their therapists’ actions led them to feel their preferences and wants were accommodated for in the decision-making process. For example, by a therapist drawing on a client’s previously discussed difficulties: “I find it interesting that [Therapist] brought that up but it’s there. It’s definitely there. And I know I talked about it” (E402-404). Clients felt this accommodation continued beyond assessment when deciding on therapy methods for subsequent sessions: “[Therapist] has been really good at just going with me in terms of where each session’s gone and just rolling with it and just kind of working with whatever comes out on the top” (G767-768).

Listened to and understood.

Seven clients reported that their therapists’ actions made them feel like they had been listened to and understood during the decision-making process: “I could tell

by what [Therapist] was suggesting that [Therapist] was listening to me, my actual real concerns” (E531-532). This extended to clients feeling their therapist had understood their therapy wants: “I think everything [Therapist] said there was- deeply understood perfectly how I felt” (G317). This understanding was also true for clients’ preferences: “it was clear that [Therapist] had been listening which was quite cool, like get my preference” (I27-28).

Clients felt comfortable engaging with the decision-making process.

Eleven clients said that they felt comfortable engaging with the shared decision-making process. This included saying their preferences: “I was comfortable there and I think because it was more of a way into the sessions as well” (A469-470). One client attributed their feeling comfortable to the flexibility they saw from their therapist: “I think I would say. I think because I feel [Therapist] gave me so much flexibility and flexibility in terms of how I want it to go about the approach” (E522-524). Four of these clients felt comfortable to challenge or reject their therapist’s suggestions if that client felt their preference was not understood.

In being comfortable to take part in the shared decision-making process, six clients felt it was empowering to be involved in their treatment decisions and to have some control over them. One client reports: “It made me feel empowered, but it also then it made me feel like I was empowered by myself” (E30-31).

Daunting for clients to be asked to take part in the decision-making process.

Four clients felt their therapists’ attempts to involve them in the decision-making process were daunting:

I don’t know. I think sort of being asked was quite daunting... But you go from sort of quite daunting like “I want support but I don’t know what

support”. And then like, being given that small amount of support like calms you down a bit because you’re being shown what support you’re getting. (C171-178)

Another client recalled a similar daunting feeling when unable to answer their therapist: “not really sure at this point. So, it’s kind of a like a sigh of ‘Oh god, I’m being asked what else and I can’t really think of anything’” (H290-291). Clients reported this daunting feeling subsiding when their therapist provided additional information on what the decision might mean moving forward.

Table 4 shows the number of coded meaning units contributing to each category across interviews and clients.

Table 4

Coded meaning units contributing to each interview across interview styles and clients

	All	IPR	Review point
	Codes (Clients)	Codes (Clients)	Codes (Clients)
<i>Perceptions of sharedness</i>	193 (14)	136 (14)	57 (8)
Shared, but more therapist-led decision-making	83 (13)	59 (13)	24 (6)
Shared leadership over the decision-making process	96 (12)	64 (11)	32 (8)
Shared, but more client-led decision-making	14 (4)	13 (4)	1 (1)
<i>Therapists supporting clients to become more active in the decision-making process</i>	320 (14)	262 (14)	58 (8)
Helping clients to articulate suggestions and wants	122 (14)	97 (14)	25 (7)
Explicitly inviting clients to contribute	152 (13)	125 (13)	27 (7)
Acknowledging clients' expressed preferences and suggestions	41 (7)	37 (7)	4 (2)
Providing opportunities for clients' input	5 (3)	3 (2)	2 (2)
<i>Both parties presenting and recognising expert knowledge</i>	197 (13)	123 (13)	74 (9)
Therapists contributing specialist psychotherapy knowledge	113 (13)	69 (13)	44 (6)
Clients demonstrating a willingness to consider the therapist's expert knowledge	44 (13)	22 (9)	22 (9)
Clients sharing specialist knowledge about themselves and their preferences	40 (12)	32 (12)	8 (3)
<i>Clients felt recognised as an individual and accommodated for by their therapist</i>	117 (12)	69 (12)	48 (8)
Decisions were relevant to and useful for clients	64 (10)	26 (9)	38 (7)
Clients, their preferences, and their wants were accommodated for	38 (8)	29 (8)	9 (5)
Listened to and understood	15 (7)	14 (7)	1 (1)
<i>Clients felt comfortable engaging with the decision-making process</i>	70 (11)	55 (11)	15 (6)
<i>Daunting for clients to be asked to take part in the decision-making process</i>	7 (4)	7 (4)	0 (0)
Total	904 (14)	652 (14)	252 (11)

Core category

Using grounded theory analysis, a preliminary model emerged from the IPR and review point interview data to indicate how clients experienced the shared decision-making process in pluralistic therapy for depression. Clients experienced this process as one in which their therapists offered specialist psychotherapy knowledge and provided clients with opportunities to offer information about themselves and their wants for therapy. In most instances, clients were immediately comfortable to contribute to these discussions. However, clients at times had difficulty when contributing to decisions discussions. Clients in these instances had difficulty defining or structuring their suggestions and wants or felt that taking part in decision discussions was daunting. Clients became more comfortable in contributing to decision discussions following actions from their therapist. Such actions consisted of, first, therapists used their expertise to make suggestions grounded in their client's previous speech. Having these suggestions grounded in clients' own words, preferences, and experiences led them to feel listened to and understood by their therapist. Second, therapists offered additional knowledge about what a decision might mean for the psychotherapy treatment. Clients reported being open to considering these suggestions and additional information from their therapist and wanted their therapist to be aware of this openness. This openness was due to clients seeing their therapist as an expert in psychotherapy that could offer alternative perspectives or knowledge that the client did not hold. Clients who contributed to the decision-making process felt their therapist acknowledged their contributions and reassured them that it was okay to be making those contributions. As such, clients felt encouraged to contribute to future contributions. Clients felt that having their contributions in the decision-making process made them feel their

preferences and wants were accommodated for in the final decision. Combining these contributions with their therapists' knowledge and expertise led clients to feel the resulting decisions were relevant to them and useful for their forthcoming treatment.

The six categories and their components resulted in a single core category, coded as: clients in pluralistic therapy experienced a shared decision-making process that could be led more by one party and was a positive, useful process for making treatment decisions in which their therapists encouraged participation and progressively supported them when they had difficulty contributing to that process.

Discussion

The present grounded theory analysis aimed to develop an understanding of clients' experiences of shared decision-making. The present analysis offers insights into who was leading the shared decision-making process, what the impact of that process was on the client, and what elements of the interaction were helpful for facilitating the approach.

How did clients experience the shared decision-making process?

Most clients felt comfortable engaging in the shared decision-making process. These findings are similar to those from healthcare that have shown patients to be comfortable in taking part in shared decision-making interventions before treatment (Paraskeva et al., 2016). Clients' feeling comfortable engaging in the shared decision-making process fits patients' reports from the United Kingdom that they want to be involved in decisions about their care (Ahmad et al., 2014). Together, Paraskeva et al. (2016) and Ahmad et al. (2014) imply that clients and patients want to be involved in the decisions around their care, with the present findings adding that they can be comfortable with doing so.

Clients also reported instances where it was daunting to take part in a shared decision-making process. However, these reports were in a minority of instances, for a minority of clients. These minority instances are important for holistically understanding clients' shared decision-making experiences as they help fulfil the standards of validation for a grounded theory: presenting a comprehensive account that provides generality by being inclusive of variation and applicable to a range of contexts (Glaser, 1978; Strauss & Corbin, 1990).

What was the impact of the shared decision-making process on the client?

The present analysis offers new findings to show shared decision-making can be a positive, beneficial experience for clients and their treatment in psychotherapy. Clients felt they were listened to and understood, had their needs and preferences accommodated for, and that the resulting decisions were relevant for themselves and their therapy. These reports share similarities with healthcare patients that felt their shared decisions were relevant, helpful, and useful for them (Paraskeva et al., 2016). The present clients' reports also share similarities with patients who felt satisfied with their shared treatment decision-making (Brom et al., 2017). Together, these findings imply that clients can have a positive experience taking part in a shared decision-making process with their practitioners. Moreover, the similarities between the psychotherapy and healthcare experiences of shared decision-making imply the approach has a potential positive impact on clients and patients across helping professions.

There is the potential that the present client sample could have evaluated their experiences of shared decision-making more positively than they were. This is due to clients being informed of the purpose behind their participation in research alongside their pluralistic treatment and perhaps wanting to show the treatment in a positive

light to Research Clinic staff. However, clients were encouraged at the start of both interviews to offer honest evaluations and responses, whether positive or negative. Any negative feedback was suggested to the client to be useful for developing the treatment in the Research Clinic. Clients were also assured that their interview was independent of their ongoing treatment and that what they said during interview would not be disclosed to individual therapists. Framing the interviews in this way likely helped accommodate for the potential demand characteristics.

Who was leading the shared decision-making process?

Clients reported instances of shared decision-making they thought had equal leadership, and others that were led more by themselves or their therapist. These findings support those of Quirk et al. (2012) that showed therapists can take more of a lead in shared decision-making, as well as encourage clients to take more of a lead. The present analysis and findings from Quirk et al. (2012) support the notion that decision-making exists on a continuum from client-led, to therapist led (Cooper & McLeod, 2011). The present findings support the notion of continuum to suggest that a spectrum of shared decision-making exists within this continuum. This spectrum would feature decisions that were shared, but more therapist-led, to shared equally between parties, to shared, but more client-led.

What elements of the interaction during the decision-making process were experienced as helpful by clients for facilitating shared decision-making?

A helpful element for facilitating shared decision-making was for therapists to encourage and support their clients to be active in the decision-making. Clients felt this encouragement and support occurred in four ways. One way consists of therapists leaving gaps in their speech to provide clients with opportunities to participate in decision discussions. Therapists also used more explicit methods such

as inviting the client to contribute to discussions or work with them to frame contributions. Clients felt their therapists acknowledged their suggestions in decision-discussions and encouraged them to participate further. These therapist actions for facilitating shared decision-making are similar to helpful therapist-related factors from pluralistic therapy, including the therapist being accepting and respectful, reassuring, as well as offering non-intrusive guidance (Antoniou, Cooper, Templer, & Holliday, 2017).

The helpfulness for facilitating shared decision-making of therapists encouraging and supporting clients' involvement shares similarities with findings from healthcare contexts. For example, Henselmans et al. (2017) showed that patients can provide additional preference talk when their practitioner offers empathy, clarification questions, or probing questions. Henselmans et al. (2017) also shows that patients did not provide additional preference talk when their practitioners provided information, neutral responses, or personal agreements. In contrast, clients in the present analysis felt that their therapist offering additional information helped with a feeling that taking part in decision-making was daunting.

Clients felt that both parties presenting their specialist knowledge was a helpful element for facilitating shared decision-making. This shows that the shared decision-making clients experienced in the present study aligns with formal recommendations for shared decision-making practice. For example, that practitioners should contribute treatment knowledge and evidence, and clients should communicate their ideas, values, and preferences (Charles et al., 1997; Chong et al., 2013; McKay, 2011; Towle & Godolphin, 1999). Moreover, the present analysis offers new findings to show that clients found their own willingness to consider their

therapists' suggestions using that specialist knowledge as helpful for facilitating shared decision-making.

Limitations

Three clients were unable to take part in review point interviews following their fourth treatment session. This was due to unplanned treatment endings and limited client availability. These missing interviews could have been valuable for further developing a comprehensive understanding of clients' shared decision-making experiences. For example, if a single client's experience deviated from the categories already established, then including that data in the final category structure would have been valuable. However, two elements of the present study's data collection and analysis help to accommodate for this limitation. First, categories began to saturate at the eleventh participant, indicating that much of the variety in clients' experiences had been captured. Second, most categories had a greater number of codes at IPR interview compared to review point interview. This increased frequency implies that a majority of data about the three clients' experience were captured during IPR interview. Moreover, the number of clients within the final analysis remained appropriate for the code-based analysis used (Bertaux, 1981; Creswell, 1998).

The present analysis did not report on barriers to shared decision-making or unhelpful aspects of the interaction. However, this analysis does not omit negative experiences of shared decision-making, only those experiences indicated not to be shared decision-making. For example, initial coding of meaning units did code for unhelpful aspects. These codes contained concepts such as clients feeling they needed more time to develop a relationship with their therapist before taking part in the treatment discussions. These concepts were not included in the final structure as

they referred to the absence of or obstructions to sharing decision-making, rather than experiences of the approach occurring. These clients' reports share similarities with findings from the field of child and adolescent mental health. For example, Abrines-Jaume et al. (2014) examined practitioners' experiences of shared decision-making. The practitioners found implementing shared decision-making to first be challenging, although this became easier as they moved through three stages of implementation: apprehension; feeling clunky; and integration. The indications from early stages of the present analysis and findings of Abrines-Jaume et al. (2014) suggest that a barrier to shared decision-making could be an unfamiliarity with the practice or the other party in the decision discussion. Therefore, future research could examine a wider range of shared decision-making determinants. These should be inclusive of barriers or obstructions to shared decision-making, such as a need for more time to practice the approach or develop a relationship with the other party.

Implications for research and practice

The present analysis shows that clients could be comfortable or daunted by being asked to take part in shared decision-making. These differences imply that clients can have different preferences for how much they are involved in the decision-making process. This shares similarities with Towle and Godolphin (1999) who introduced the question of how much patients should be aware of and involved in shared decision-making. They suggest physicians establish patients' preferences for involvement, as well as for amount and format of information. Other researchers have asked whether patients should be informed that they are engaging in shared decision-making. Borrell-Carrio, Suchman, and Epstein (2004) suggest that offering the patient the option of more or less autonomy may be ideal practice. Similarly, O'Connor (1995) and colleagues (O'Connor et al., 1998) have designed decision-

aids to elicit the amount of involvement clients want to have when sharing decisions. McKay (2011) supports the notion of accommodating for these involvement preferences. McKay noted that therapists in their shared decision-making intervention should elicit client preferences for metacommunication. Together, this conceptual and empirical evidence implies practitioners that want to use shared decision-making should maintain an awareness that not all clients may want to the same level of involvement in decisions.

The present analysis provides an understanding of clients' experiences of shared decision-making, although other methods could offer additional perspectives. Doing so would move the field closer towards a holistic understanding of shared decision-making in psychotherapy. For example, researchers could use IPR interviewing and a grounded theory approach to investigate therapists' experiences of shared decision-making. Such an analysis would be directly comparable to the present analysis. Gaining therapists' perspective would also be useful to understand any gaps between clients' and therapists' perceptions of leadership, as previous findings showed perceptions of decision-making leadership can differ between patients and practitioners (Seale, Chaplin, Lelliot, & Quirk, 2006). Second, the use of ethnomethodology or conversation analysis could examine shared decision-making as it occurs in situ. Conversation analysis would offer a third, objective perspective outside clients' and therapists' views.

Conclusion

The present grounded theory analysis developed an understanding of clients' shared decision-making experiences in psychotherapy. Clients in most instances were comfortable taking part in shared decision-making and had positive experiences. However, some clients found it helpful for their therapist to offer

encouragement and support to become more active in decision discussions when they experienced difficulty contributing to the shared decision-making process. The findings suggest that psychotherapy clients likely have different preferences for how much involvement they want to have in their treatment decisions. Therefore, therapists practicing shared decision-making should strive to be aware of these potential differences in preferences and recognise that decision-making can remain shared even if led more by themselves or their clients.

Chapter five: A conversational analysis of goal decision-making in pluralistic therapy

The previous chapters adopted methodologies that used wide perspectives to examine how shared decision-making occurs in psychotherapy: first, by examining the available research within this context (Chapter, 3), and second, by comprehensively examining clients' reports of their experiences of the shared decision-making approach (Chapter, 4). Therefore, it would be appropriate to examine these interactions in detail to enhance any understanding of shared decision-making in psychotherapy. To do so, Conversation Analysis will offer in-depth descriptions of the actions clients and therapists use to negotiate decisions in pluralistic therapy. Describing these actions will likely yield findings that contribute to the third aim of the present thesis; to identify what the properties of a shared decision are in a psychotherapy context.

Decisions and negotiations within talk-in-interaction

Conversation analyses and descriptions of decision-making talk from general contexts can contribute to an understanding of how decisions can be made in a psychotherapy context. For example, Huisman (2001) described decision-making within four information technology and hospital management groups. Huisman's analysis showed that decisions can be formed as joint process between participants. These participants jointly constructed a state of affairs through providing implicit or explicit assessments of the actions, events, and situations relevant to the decision discussion. Participants would then formulate commitments to a future state of affairs or course of action.

Decision-making can also be predominantly determined by one individual's assessment of another's actions or intentions. For example, Larsen (2013)

demonstrated how emergency call takers made decisions about whether that call was deemed an emergency. Larsen (2013) showed that callers would provide claims of entitlement, such as 'I must'. Call-takers reflected this entitlement by immediately collecting information to forward to appropriate services, rather than gathering further information about the event. This finding implies that callers can provide claims to entitlement alongside requests for emergency assistance to bypass questioning for extraneous information. In doing so, callers can avoid talk that could delay their request or reduce the chance that they receive assistance. However, the sequences Larsen identifies may differ from a psychotherapy context as they likely lack the urgency of an immediate decision needed to address an emergency.

Decisions can also be impacted by actions extraneous to the participants and talk. Theobald (2013) examined disputes between children, describing how decisions on how to proceed with play can be determined by behaviour outside of the discussion. Theobald showed that despite children claiming ownership of an idea or game, holding the title of owner did not give the child lasting authority over the direction of the game. Instead, the direction and upholding of the game was determined more by the other childrens' uptake of the game and the use of proposed game objects or ideas.

Together, the analyses of Huisman (2001), Larsen (2013), and Theobald (2013) demonstrate that decision-making can be impacted by the actions of interactants or institutional entitlements. Moreover, actions extraneous to the talk can modify those entitlements. It would therefore be appropriate for an examination of psychotherapy decision-making to recognise these actions and determine if they are transferrable across contexts.

Decision-making in helping professions

The research examining decision-making processes in healthcare and mental health suggests that a decision-making process can involve multiple participants but be influenced predominantly by one party. Boyd (1998) reported a Conversation Analysis of negotiations for patient medical treatment decisions between groups of two medical practitioners. Boyd showed that practitioners initiating a discussion using patients' history can lead the trajectory of the discussion. Within this, the information decided as relevant to the discussion is often announced by the same party that initiated the talk. Although, Boyd noted that the other participants in the discussion may introduce alternative relevancies through direct suggestions. However, these can be resisted or rejected by the other party based on clinical or professional opinions.

A practitioner in healthcare can take actions in decision talk to elicit a patient preferences or suggestions, and so can alter the involvement of each party in decision-making. For example, Heritage and Robinson (2006) present their analysis of primary care physicians and patients in community clinics. Practitioners would elicit patient information early in these interactions using general inquiries. Such inquiries invited patients to present their medical needs or difficulties they were seeking assistance with. These invitations helped patients to present the knowledge on their own terms, with little constraint placed on those patients' involvement in discussions. For example, Figure 2 shows a practitioner using an open question to invite a patient to describe the pain they have been experiencing. The patient responds by presenting their account of what they think might be causing their pain in their own words.

Figure 2

Heritage and Robinson's (2006) general invitation question example

01 a-> DOC: S:ɔ̃(.) tell=me about this pain you're getting.
 02 (0.4)
 03 b-> PAT: It (.) it (.) I thought (at=f:)- initially it was
 04 b-> uh (0.2) just my sciatica (.) acting up. ...

Heritage and Robinson (2006) also report that physicians presented requests for confirmation. These requests served to demonstrate their understanding of patients' medical needs. Doing so invited a yes-no response from the patient and encouraged them to provide further information. However, practitioners also used these questions to confirm specific symptoms rather than general concerns. For example, in Figure 3 a practitioner's confirmation request constrains the responses available to a patient. In doing so, the practitioner steers the patient away from elaborating on the symptoms that the professional has demonstrated themselves to be knowledgeable in.

Figure 3

Heritage and Robinson's (2006) confirmatory question example

01 a-> DOC: Okay so this time last for three da:ys,
 02 a-> ·hhh an' you're having body a:ches,
 03 PAT: Y [es:::]
 04 a-> DOC: [You('re) feelin' we:ak,] ·hh uhm any other
 05 a-> symptoms, right no:w=
 06 b-> PAT: =N:ɔ̃:.[(It's) just that I woke-]
 07 HT> DOC: [Fe:ver::_]]
 08 PAT: N:ɔ̃ uh no fever.

Heritage and Robinson's (2006) patient information eliciting questions would be applicable to psychotherapy decision-making. These questions could alter the amount and type of information clients offer in decision discussions. Therefore, influencing clients' engagement in the decision-making process.

Other analysts have shown that the amount of patient engagement in decision-makings can be constrained by practitioners' actions. Antaki, Finlay,

Sheridan, Kingree, and Walton (2006) present their analysis of decision-making in a group setting for service users living with an intellectual disability. These groups aimed to empower service users to offer their voice to discussions. Antaki et al. (2006) showed that the groups could be led in a way contradictory to this aim. First, by group leaders promoting the meeting as a place for group decision-making meeting, but then leading each step of the decision-making process themselves. Second, by the group leaders providing little room for service users' suggestions or contributions. These findings imply a potential for collaborative discussions to be led by the practitioners more than intended. Doing so limits patients' opportunities for input using their own voice.

Patients can also resist practitioners' suggestions using open disagreement or non-acceptance. Koenig (2011) shows how patients used resistance and non-acceptance of their physician's suggestions to assert their own agency in medication decisions. In doing so, the patients worked to negotiate the appropriateness of a decision for themselves and their preferences. For example, using 'mm's as a foreground to an objection rather than as a continuer. Similarly, Lindstrom and Weatherall (2015) showed that patients can show resistance to practitioner's treatment recommendations. These patients resisted explicitly through objections, or implicitly through a lack of uptake. When this resistance was in the form of weak agreement or commitment from the patient, the practitioners would offer additional information to further their recommendations. For example, figure 4 shows a patient resisting by displaying minimal agreement for the practitioner's suggestion. The practitioner then continues to advocate their recommendation.

Figure 4

Lindstrom and Weatherall's (2015) patient resistance through minimal commitment

405 DR:-> so it's probably worthwhile with you being seventy two
406 now .h to think about having a repeat (.) look
407 down there .hh just to [see-]
408 PT: [mm] yeah i [suppose so yeah]
409 DR: [just just to see]=
410 DR: =what it's [doing.]
411 PT: [yeah] .tch mm .hh well might be a good idea
412 DR: i think [it probably would]

Lindstrom and Weatherall (2015) further demonstrate that practitioners can draw on medical expertise as a basis for their recommendations. Despite this knowledge increasing practitioners' authority to make recommendations, they would ultimately defer to patients' authority for the final decision. However, patients would draw on their own medical knowledge to resist these recommendations. The practitioners accepted patients' presentation of this knowledge as appropriate to the decision discussion.

Research examining practitioner and patient interactions within healthcare and mental health contexts demonstrates that both parties can take actions to channel decision-making by constraining or resisting the other's responses. As such, it would be useful to the field to understand whether therapists and clients can channel psychotherapy decision discussions in similar ways. Developing this understanding should include an analysis of what actions might influence decision negotiations and how this can impact the final decisions.

Collaborative treatment decision-making

Within collaborative decision-making, practitioners and patients can have differing amounts of influence. Quirk et al. (2012) demonstrated that medication decisions within psychiatric outpatient consultations can be more pressured or less pressured. Quirk et al. showed that practitioners applied escalating pressure that

resulted in patients feeling they had less influence over the final decision. Other practitioners applied no pressure during decision-making. Quirk et al. also showed instances of open decisions steered by the cooperation by both the practitioner and patient (see Figure 5).

Figure 5

Quirk et al.'s (2012) example of open, shared decision-making

1	C:	.hh Well (1.0) why don't we leave things as (.) they are
2	P:	Mm
3	C:	(with this now) especially as you've had worries about
4		your mum and () =
5	P:	= Mm =
6	C:	= () and so on .hhhh and maybe if things stay
7		on a level (0.4) we might:: maybe look at alternating to
8		17 point 5 and 15? ()
9	P:	What alternate days sort of thing?
10	C:	↑Yeah::: ↓ (.) that might be one way of doing it, (yes)
11		(0.5)
12	P:	D'yer wanna do that now-°or° (0.4) next time
13	C:	Well- thhhhh (.) I think it would be reasonable to give
14		to give it a ↑try↓ =
15	P:	= Alright then (.) yeah
16	C:	Yeah? Is that gonna be ↑fiddly↓ (.) doing [that?
17	P:	[That'll be
18		Alright

The ways practitioners make suggestions in decision-making can encourage patient involvement in the decision-making. Such actions would facilitate a collaborative decision-making process. For example, Reuber, Toerien, Shaw, and Duncan (2015) examined how practitioners involved their patients in decision-making within neurology consultations. They report that the practitioners used option-listing to offer patients choices. These patients confirmed after their consultations that they felt they had been offered choice. Practitioners' also used option-listing to give their patients influence in the decision-making. However, patients at times resisted these attempts by drawing on their practitioner's professional status. Other practitioners used option-listing to emphasise their

recommended course of action. These practitioners would present their recommendations with an extreme case formulation alongside the possibility of treatment, with an alternative option presented as one that would be unsatisfactory for the patient. For example, one practitioner during a discussion about an uncertain diagnosis recommended additional testing to treat the problem, followed by a devalued option to 'just soldier on as you are' (p. 114). Rueber et al.'s findings share similarities with Antaki et al.'s (2008) earlier findings that demonstrated that speakers can deemphasise options by continuing to list them after a choice has been made. Such actions indicate to the respondent that their choice was incorrect. As such, these findings imply that the way practitioners list options could alter decision-making towards a less preferred option for a client.

Kushida and Yamakawa (2015) showed that psychiatrists in outpatient consultations made suggestions in two ways. First, practitioners used inclusive 'we' designs when patients expressed a readiness for a decision to be made. Second, practitioners used declarative evaluation designs as a more cautious approach when patients did not express readiness. As such, Kushida and Yamakawa (2015) conclude that practitioners used these designs to demonstrate an understanding of their patients' perspective of the decisions.

Together, Quirk et al. (2012), Kushida and Yamakawa (2015), and Reuber et al. (2015) show how conversational actions can influence how much involvement practitioners and patients have in decision discussions. These actions include: suggesting options to be satisfactory or not during listing, using inclusive or declarative statements, and using pressurised suggestions. These actions could hold implications for the amount of influence and involvement therapists and clients have during psychotherapy decision negotiations.

Goal decision-making in psychotherapy

The pluralistic therapy in the present thesis encourages a therapist and client to create therapy goals during assessment or initial treatment sessions (McLeod & Cooper, 2012). As such, decisions made by dyads in the present treatment likely included goal negotiations and decision-making. Research examining goals in psychotherapy shows that practitioners can attempt to share goal decisions with their clients. Ekberg and LeCouteur (2014) showed that therapists *co-implicated* clients in the decision-making process. Ekberg and LeCouteur referred to co-implication as therapists' invitations for clients to contribute to formulating plans for behavioural change, as outlined in chapter 3. The present study shares similarities with Ekberg and LeCouteur (2014) by examining therapy-based negotiations. However, the present study examines all negotiations of clients' therapy goals, rather than plans for behavioural change as part of cognitive treatment only.

Goal setting and negotiation is a key practice within the pluralistic therapy context of the present investigation. This practice emphasises both client and therapist involvement in these negotiations (McLeod & Cooper, 2012). Within pluralistic therapy, goals are useful for structuring the therapeutic process and can be used to shape the direction of the therapy (Cooper & McLeod, 2011; McLeod & Cooper, 2012). Moreover, pluralistic therapy affirms the importance of a client's agency in their own treatment and change, suggesting practitioners use a shared decision-making approach to create therapy goals (Cooper & McLeod, 2011). Coupled with the evidence that the actions of interactants can channel decision-making or alter the contributions from each party, a clear research aim presents itself: to describe the conversational methods used by clients and therapists for negotiating and setting goals within adult pluralistic therapy.

Method

Methodological considerations

Conversation analysts emphasise the notions of emergent findings and *unmotivated looking*, whereby findings are drawn from observation rather than from theoretical deduction (Sacks, 1984). Therefore, the conversation analysis began with an aim of describing decision talk. This aim evolved into a single research focus on examining goal decision-making talk across therapy in depth. However, the present analysis is not fully unbiased by previous knowledge. This analysis drew upon the existing psychotherapy literature and research to help contextualise conversational moves in terms of their normative functions. The researcher was also familiar with shared decision-making research data, therapeutic culture, and pluralistic therapy. This familiarity aided in recognising instances of talk used as therapeutic methods, rather than as everyday talk (Leudar, Sharrock, Hayes, & Truckle, 2008).

Setting

The present Conversation Analysis drew on audio recorded treatment sessions from Pluralistic Therapy for Depression within a University Research Clinic (Chapter 2).

Participants

The data corpus included six therapy dyads. These consisted of three female therapists and two male therapists. Therapists were fully qualified counsellors, psychotherapists, or counselling psychologists, as well as experienced trainee Counselling Psychologists. Therapists received training in practicing pluralistic therapy.

A majority of the client sample were female and white British (83.3%, $n = 5$). Half of clients reported a disability and one client reported taking anti-depressant

medication at the time of treatment. Clients included both first time clients ($n = 2$) and those who had previously received treatment at another service ($n = 6$). Clients ranged from age 18 to 34 ($M = 22.7$, $N = 6$), with most between the ages of 18 and 23.

Case selection

The present analysis used a focused case selection approach to increase the probability of identifying examples of the interactive processes or target phenomena of interest (Muntigl & Horvath, 2014). Clients' audio recorded sessions were examined if the client had evaluated their assessment decisions during their Interpersonal Process Recall interviews overall as equally shared, or shared but led more by a single party (Chapter 4). This reduced the number of potential clients to include in the analysis from fourteen to six.

Eligible extracts were identified based on whether they contained a focus on goal setting and negotiation. Extracts were included from clients' assessments, as well as therapy reviews at session four and 10. These are sessions where goal setting and negotiations are emphasised in pluralistic therapy protocol for depression (McLeod & Cooper, 2012). This protocol advises dyads to revisit the Goals Form in the therapy review sessions and encourages discussion around any changes to these goals.

The final data corpus consisted of eighteen extracts of assessment and therapy review point sessions. An additional extract was identified but later excluded as the audio recording ended due to constraints that were external, such as a time limit was reached for the therapy session. The 18 extracts contained instances of goal setting, goal negotiations, and decisions to not use goals in the therapeutic work. Extracts included instances of spontaneous goal negotiation, and of goal setting as a

structured activity using formal tools such as the Goals Form (Cooper, 2015). Goal discussions often occurred in the second half of assessment sessions and the first half of therapy review point sessions.

Analytic Procedure

The researcher transcribed each extract, with the accuracy of these examined at data sessions at the University of Roehampton. All transcripts used the Jeffersonian transcription system, a standard approach to conversation analysis transcription (Atkinson & Heritage, 1984). Once transcribed, descriptions were compiled of the actions and sequences within each extract. At this stage, initial analytical notes were made on the actions of the participants, the turns they were performing, and how this might impact the goal setting or negotiations. For example, whether clients and therapists were aligned immediately in performing a goal setting activity or not, or whether this occurred later in the extract.

Next, two dyads were selected for within-case analysis. Within these dyads, one therapist was a fully qualified practitioner, and the other an experienced professional doctorate trainee. One client had previously received treatment from other services and the other had not previously received any long-term treatment. All extracts were examined for one dyad and descriptions created of each extract's talk-in-interaction sequences and any methods used by therapists and clients to arrive at goal decisions. These extracts and their descriptions were then compared to each other, as well as to the extracts from the second dyad. From this process, preliminary, non-exhaustive analytical categories were created.

The remaining extracts from all other dyads were then compared to the analytical categories, amending existing categories or creating new ones if needed. This process shaped the existing analytical categories to the data rather than allowing

the categories to determine the fit of the data. Counter-evidence was then considered, and categories revised if appropriate. The categories and their explanations were reviewed by other analysts at data sessions taking place at the University of Roehampton¹.

Analysis

Goals

Goal decisions were not required to correspond to a pre-existing theoretical definition of a goal to be included within the analysis. Instead, extracts were deemed to include goals if the goals were defined by what the members of the interaction oriented to as a goal. For example, after introducing a goal setting activity a therapist and client might refer to subsequent goal setting as what the client might want to work on during their time in therapy. This included extracts where decisions were made to not work with goals within treatment.

Therapists initiated goal decision-making in different ways. Goal decisions were often initiated by therapists presenting the Goals Form to the client (Cooper, 2015; see Appendix B1). However, goals were also included that were created before the Goals Form was present. For example, one extract features a goal setting activity framed by the Goals Form (see Extract 1a). Whereas, another extract shows how the form was present but was not directly referred to until after the goal decision was made (see Extract 1b).

Extract 1a

Dyad E assessment session, 79 minutes

¹ Thanks to John Rae, Jacqueline Hayes, Sarah Cantwell, and Paul Dickerson, University of Roehampton.

1 T: okay (0.8) erm one thing that I find helpful to do i:s
 2 (.) e:r (0.5) like (.) it's a little bit ((shuffling
 3 papers 1.7)) erm I've another piece of paper (.) but it's
 4 just when your kind of looking at where yo- this might
 5 g:o is to (.) think about some goals that you might set
 6 for [yourself.
 7 C: [yeah,
 8 T: and that could be like you said not (0.7) feeling as shit
 9 C: yeah,
 10 T: er:m (1.7) but so that we can sta- see where you are now
 11 and this is also part of our outcome measures and see
 12 where yo:u (0.7) you get t:o.
 13 C: yeah,

The therapist repairs their presentation of the Goals Form. That is, they alter their original presentation of the Goals Form from “a little bit” in line 2 to ‘another piece of paper’ in line 3. With the Goals Form present, the therapist suggests what information could contribute towards therapy goals. The therapist then offers a further explanation of the form and the importance of its use within the goal setting activity (line 11).

Extract 1b

Dyad D assessment session, 60 minutes

1 T: do you mind having a (.) what do you think about- what do
 2 you ima:gine °oh god° ((seat movement)) what do you
 3 ima:gine ((seat movement 1.4)) would be a goal that you
 4 would like anything (1.2) >I mean< is there anything that
 5 you feel like actually you could set as a go:al that you
 6 would like (2.2) to achieve either (1.7) in the longer
 7 term or even something between now and next time that we
 8 meet, it's entirely up to you really.
 9 (2.7)
 10 C: I suppose sort of (0.6) like (.) what we were saying
 11 before like (0.7) I guess like being able to make
 12 decisions confidently?
 13 T: alright! well let- yea-! go on then put that down that
 14 sounds quite good,
 15 C: °cool°
 16 ((C typing 4.5))

Extract 1b differs from extract 1a as the therapist does not immediately present the Goals Form to the client. The form is likely present within the session, as the therapist's turn in line 1 begins with ‘do you mind having a’. Yet, the therapist

instead chooses to bypass explicit references to the form to refer directly to the client and what ideas they may have about a goal. The therapist creates a minimal framework for the creation of the goal: that it should be something the client would like to achieve, as well as that it must attend to a temporal component ‘in the longer term or even something between now and next time’ (lines 6-8). Once the goal has been suggested by the client, the therapist proposes the client writes it on the Goals Form (Figure 6).

Figure 6
Goals Form

Goal 1:						
Not at all achieved 1	2	3	4	5	6	Completely achieved 7

Therapists and clients drew on two types of content as relevant to goal negotiations. First, they drew on prior content that consisted of information from discussions earlier in that treatment session or in an earlier treatment session. This information concerned difficulties or problems that clients were experiencing. Second, parties drew on local content that consisted of information presented and managed by either participant within the immediate discussion. This could include a client’s difficulties or problems, but also suggestions from the therapist on how to work with these. The use of both types of information by participants to structure for their goal setting can be understood as a form of *structured immediacy* (Leuder et al., 2008). This concept refers to how interactions take place in the “here-and-now” and are locally managed, but also social practices constituted by exophoric circumstances managed by participants (p. 866). Exophoric details in the current context refer to information from a therapist or client that was often not introduced for the first time

within the extracts as the information was likely deemed to be relevant in earlier discussions. For example, if the information concerned a difficulty the client wanted to work on in therapy had been discussed by both parties earlier as an appropriate, potential focus for treatment. There were often instances in the corpus of both parties making implicit references to these earlier discussions.

Therapists introduced goal setting activities for the first time within clients' assessment sessions. These introductions often shared common features. For example, therapists began their introductions with a summarising phrase followed by a pause, such as 'so' or 'okay' to indicate the previous topic was concluded, and a new one was beginning.

Extract 1c

Dyad C assessment session, 38 minutes

- 1 T: and <now if- do you have go:als for yourself.> (0.9)
- 2 other goals (0.5) or other ideas of (2.5) what you would
- 3 want to work on (0.5) in our >time together?< (0.7) here.
- 4 C: er:m (2.7) I don't know really kno:w. (2.8) (I don't)
- 5 (3.8) (I really don't) (3.6) to feel better? ↑hehuh.
- 6 T: yes.
- 7 C: yeah. (eventually).

Therapists also frame the goal setting activities as relating directly either to the collaborative work between themselves and their client 'what we might do', or the client only 'what you might work on'. For example, in extract 1c the therapist emphasises that the goals to be created would be based on the client's own wants for the therapy work (lines 2-3). However, the addition of 'time together here' at the end of the therapist's query in line 3 relates the activity to the collective therapy work.

Extract 1d

Dyad E assessment session, 79 minutes

1 T: okay (0.8) erm one thing that I find helpful to do i:s
2 (.) e:r (0.5) like (.) it's a little bit ((shuffling
3 papers 1.7)) erm I've another piece of paper (.) but it's
4 just when your kind of looking at where yo- this might
5 g:o is to (.) think about some goals that you might set
6 of [yourself.

Therapists would offer justifications for why the goal setting activity should be used, with many adding a recommendation for the activity as helpful. However, this differed across therapists as they referred to the goal setting activity as generally helpful, helpful for other people coming into therapy, or helpful for the therapist.

Extract 1d shows the therapist in line 1 introducing the activity of goal setting as an activity that is personally helpful to them. As such, the therapist is immediately recommending goal setting as helpful based on their own opinion and what they have found helpful in the past either professionally or personally.

Extract 1e

Dyad B assessment session, 21 minutes

1 T: okay, that sounds good what would be good to do if you're
2 okay is to (0.5) erm think about kind of go:als. (0.5)
3 just like where you'd like I mean- and I think you've
4 been talking a lot about that already? about kind of like
5 we're going to work togethe:r, (.) where would we want to
6 get to.

In most therapists' presentations of the first goal setting activity, the activity was framed to be optional for the client. Often this would include a brief consent check and pause from the therapist, before continuing to introduce the activity. For example, extract 1e shows a therapist introducing a goal setting activity using these elements. The therapist in line 1 signifies the end of the previous talk with an 'okay' and suggests the usefulness of the activity as 'good to do'. They then perform a

consent check with the client in lines 1 to 2 before proceeding with the activity ‘if you’re okay’. This therapist outlines a framework for the goal setting activity as attending to both the client’s wants ‘where you’d like’ (line 3) and the collective therapeutic work ‘we’re going to work together’ (line 5).

Analysis revealed that following therapist’ commencement of goal setting activities, both parties’ talk followed one of three trajectories with notable alignment or misalignment with the goal-setting activity. Therapists then had a choice about how to proceed with the goal negotiations in relation to the responses or suggestions their clients made. These dyads performed goal negotiations in three broad ways across the 18 extracts (Table 5).

Table 5

Ways of performing goal negotiations within pluralistic therapy for depression

	Extracts	No. of dyads	Dyads
Client and therapist aligning and setting up the relevancies together	10	5	A, B, C, D, E
Repaired alignment and co-setting up of relevancies following therapist scaffolding	6	4	A, B, C, E
Therapist scaffolding following client misalignment	3	1	A
Clients leading the establishment of relevancies for the goal negotiation	5	3	B, C

Client and therapist aligning and setting up the relevancies together

Goals were negotiated by therapists and clients setting up the relevancies for a goal decision together. Within this way of conducting goal negotiations were ten examples of therapists and clients co-constructing the content of goals following alignment or repairs to that alignment.

Extract 2a

Dyad B assessment session, 21 minutes

1 T: okay, that sounds good what would be good to do if you're
2 okay is to (0.5) erm think about kind of go:als. (0.5)
3 just like where you'd like I mean- and I think you've
4 been talking a lot about that already? about kind of like
5 we're going to work togethe:r, (.) where would we want to
6 get to.
7 C: mhm.
8 T: and it sounds like if it's okay ill j[ust
9 C: [↑mhm
10 T: write them do:wn. but it sounds like ((C cough)) one (.)
11 I guess was about- (.) >you know there could be a few<
12 but one you've talked about is really kind of
13 understanding (0.5) um (0.5) kind of to (.) underst: and
14 (1) why I'm (.) how would you phrase it?
15 C: u:m. wh:y (1.3) I would say why I (1.4) I (.) feel and
16 behave just the way (1.4) that I (1.3) ↑d::o
17 T: heheha
18 C: um:↑hehum in terms of (5.5) I would say probably
19 achieving a go:al, (1.6) be it small or be it big.
20 T: so something about to understand why?
21 C: yeah why I, (0.6) I feel this (0.6) certain way or
22 beha:ve (1.8) this (1.8) this (0.7) way I don't know
23 (1.2) °what is the good word° (distortion) all or nothing.
24 T: yeah.
25 C: all or nothing.
26 T: it's something about understanding why you get to that
27 place [isn't it?
28 C: [yeah of the all or yeah exactly yeah.
29 T: so,
30 C: mhm
31 T: if we were going to write it down it would be something
32 about- let's just try- this sometimes- ↑is it okay to
33 write these down.
34 C: ↑yeah no that's great for me, I like [to write=
35 T: [so-
36 C: =everything be[cause I forget ↑hehehahaha
37 T: [↑you like to write everything heha that's
38 two of us °then°.
39 C: ↑herha
40 T: so it'd be ↑something about (.) to (.) understand, (.)
41 why (2.1) I (.) get (.9) ((C coughing)) to (.) a place
42 (.) of (.) what would you call it? o- of all or nothing?
43 C: m:hm. o:f.
44 T: and is it I don't know how would you describe that
45 [place=
46 C: [↑ah
47 T: =it's kind of a bit (.) ma:nic?
48 C: it's like just sort of (1.4) doin::g ((bracelets
49 jingling))
50 T: activi[ty isn't it?
51 C: [excessive- excessive-
52 T: ↑yeah
53 C: doing. yeah could be excessive activity.

The therapist in the first line initiates the activity of goal-setting, leaving a gap for the client to respond. The client's lack of an objection suggests to the therapist that they have permission to continue. The therapist increases the relevant importance of this activity through procedural linkage. Procedural linkage here refers to a speaker suggesting that the new topic or suggestion is similar to a previous topic (Werth, 1984). At line 6 the therapist does not indicate that their turn might have ended, and so the client responds with a confirmation of understanding. This confirmation implies permission for the therapist to continue with the goal setting. This happens again at lines 8 and 9.

At line 10 the therapist draws on the client's previous speech from earlier in the session, without fully completing a suggestion. The therapist positions the client as the knowledgeable authority on this topic at line 14 by asking them 'how would you phrase it'. The client then responds by completing the therapist's suggestion. In lines 15 and 16 the client displays difficulty and a possible non-verbal thought process as they often pause when finishing their suggestion.

The therapist at line 17 laughs with a rise-falling contour, reflecting the client's turn end from the previous line ending with an emphasised upwards intonation. This latter upwards intonation could be a display of humour within the client's difficulty in presenting their thinking. This laughter channels the goal negotiation, demonstrating to the client that they may need to add more information for a satisfactory response. The client uses this cue to offer an addition to their previous suggestion. The therapist employs another channelling continuer to conclude their question in line 20, seeking clarification from the client. The client continues to show this difficulty in verbalising their thinking as a goal suggestion until line 23. They do so by directing a question to a third position outside of the

interaction in the style of rhetorical questioning, before halting their previous suggestion and presenting a new term.

The client in line 25 repeats their suggestion to reaffirm it or bring the discussion to a close. Yet, at line 26 the therapist does not accept this closure and instead reintroduces their previous idea of ‘understanding’ from line 13, suggesting an incompleteness to the goal as it is by line 25. Rather than closing the activity, the therapist accepts the client’s local content and progresses the activity. In doing so, the therapist draws on the client’s earlier speech to demonstrate their understanding and elicit a firm answer from the client. This answer comes at line 28 when the client gives an overlapping, strong affiliative response of ‘yeah of the all or yeah exactly’. Line 29 begins a new sub-activity of writing the goal decision.

The therapist at line 40 ends the writing activity by noting down the goal using previously agreed terms. The therapist defers to the client again at line 42 with ‘what would you call it?’. This question offers a lack of knowledge authority to recruit an answer from the client. Therefore, the therapist is suggesting that more information is needed to complete the goal or is trying to check with the client before finalising the defining term ‘all or nothing’. However, the client at line 43 does not complete their answer. The therapist again defers to the client’s knowledge in lines 44 and 45. The client offers a display of understanding at line 46, with a strong upwards intonation on their ‘ah’. The therapist then continues but pauses before offering a candidate answer. The client substitutes the therapist’s candidate answer for the emphasised term ‘doing’ alongside a non-verbal action. Both parties then offer more suggestions for the correct term in lines 50 and 51, that the therapist agrees with at line 52. The client then affiliates with the therapist’s candidate answer from line 50, repeating their own phrasing alongside their therapist’s. As such, the

goal decision is based on local content from both the therapist's and client's suggestions. In drawing on this content, both parties use lexical substitution. That is, they move from the therapist's initial suggestion of 'understanding' in line 13, to the client's suggestion of 'why I feel and behave just the way that I do' in lines 15-16, to arrive at a satisfactory goal of 'understand why I get to a place of excessive activity'.

Later in this negotiation, the dyad tests the appropriateness of their agreed decision for its fit of for the client. In doing so they also reiterate the difficulties in defining the goal content within the context of therapy room, as seen in extract 2b.

Extract 2b

Dyad B assessment session, 23 minutes

54 T: excessive- it is a kind of? [yeah.
55 C: [u:m (1.3) yeah cos it happens-
56 fit happens when everything like it even happens with
57 like physical activity like I say ↑>okay ↑I need to get
58 back into shape for example. I get an idea in my mind and
59 I'm like okay I'm going to go to the gym this and this
60 and this and then I'll go for a whole week and all that
61 but then I'm so exhausted that I can't do it again. so
62 it's like< .h activity of doing,
63 T: yeah it's kind of [excessive doing isn't it>
64 C: [mhm
65 C: yeah excessive doing, yeah,
66 T: excessive doing rath[er than, (1.2) [yeah.
67 C: [mhm [°than activity° yes.
68 T: something like that,
69 C: .h h
70 T: it's difficult to- I can hear it's kind of difficult to
71 describe isn't it?
72 C: m[m::m. mh:m.
73 T: [it's difficult to find the exact words but I do I can
74 picture it hehaha
75 C: it's the doing. ↑yea[h the doing doing doing doing doing.
76 T: [I can picture that doing slightly
77 ac- very active (.) slightly obsessive isn't [it?
78 C: [mhm.
79 T: kind of like[a bit stuck in to=
80 C: [yah.
81 T: [=ive got to do it ive got to do [it.
82 C: [yah. [yah. yeah.
83 C: yeah its obsessive more than (.) like could be a little,
84 (1.4) compulsive. but I think it's more like ((bracelets
85 jingling)) [>can't think of the word<
86 T: [excessive.
87 C: yah.
88 T: well that seems a good way of phrasing it [in terms of
89 saying why-,
90 C: [↑yeah I think
91 that's perfect
92 T: yeah?
93 C: that makes sense at least. [°for me°.
94 T: [>so to understand why I go to
95 a place< of excessive (.) doing.
96 C: of excessive doing.

Continuing from extract 2a, extract 2b starts by the therapist taking up the client's phrasing of 'excessive'. The therapist then ends their turn when the client interrupts to give evidence for the appropriateness of the goal. The client concludes their evidence in line 62 by reaffirming their chosen term from line 48, with the therapist at line 63 offering 'excessive' and 'doing' rather than the previous

‘excessive activity’ (Extract 4a, line 53). Both parties agree and repeat the new goal term in place of the old one by line 68. Line 70 sees the start of a repetitious back-and-forth of acknowledgement of the lexical terms making up the goal. Both parties test the agreed goal alongside both the client's prior and new evidence, as well as the agreed phrasing for the goal established by line 68. The therapist at line 88 offers an opinion of the appropriateness of the goal. The client agrees strongly with this position, evident in their overlapping speech, rising intonation in line 90, and their emphasis on ‘perfect’ in line 91. The therapist in line 94 offers a summary of the agreed term and finalises the activity. Within this the therapist shows their affiliation and the client confirms the goal wording by echoing the ‘excessive doing’ term from line 95.

For the extracts within this way of conducting goal negotiations, therapists frequently form the first pair part. But following aligning responses, both clients and therapists produce suggestions that require responses from the other participant. The initial goal suggestions are made most often by the therapist and are based on prior content from the client earlier in the session. As the extracts progress, the relevancies are established from the local content proposed by both therapists and clients. Both parties accept or at least acknowledge each other's suggestions. The final goal decisions are written using both clients' and therapists' words as an outcome of a lexical refinement process that both have taken part in.

Repaired alignment and co-setting up of relevancies following therapist scaffolding.

Six extracts showed a process of goal negotiation in which both parties were not initially aligned but repaired this later in the extract. This repair happened through therapists' scaffolding the activity by making suggestions, proposing

candidate answers, or encouraging clients to contribute suggestions (see Extract 2c).

Once aligned, the rest of the extracts follow in a similar manner to those in which aligned clients and therapists co-construct the relevancies for the goal decisions, as in extract 2b.

Extract 2c

Dyad E assessment session, 81 minutes

1 T: is there anything else?
2 C: er:m, (4.2) herh- (0.4) °I°- I dunno. (1.4) hurgh and like
3 I want of say feeling less crap but that kind of (0.5) is
4 a thou:sand things kind=
5 T: [m:m.
6 C: =of listed all at on:ce I guess so like.
7 T: if you (0.7) were to feel less crap what do you think
8 would need to happen for that? (1) to change?
9 C: ¶hehah
10 C: [>↑I don't know if I knew that I don't think- then I
11 probably wouldn't be here.<]
12 T: [(as in if you don't have time) ¶heheha ah]
13 C: but (.) erm (.) er (.) I don't know like (3.8) I don't
14 know because I guess if I knew that then I (.) wouldn't
15 (.) be here. and [like-
16 T: | [yeah.
17 C: I want to say kind of like just >doing more but then I do
18 more and then like kind of not and then< (.) just-
19 T: so actually maybe it's kind of trying to figure out why
20 you do feel so crap and what that i[:s?
21 C: [yeah,
22 T: and because often (0.5) that's what therapy is like (0.4)
23 I feel like this (.) I don't know why (.) I want to get
24 better.
25 C: [yeah ,
26 T: and the kind of doing bit(.) [in the middle of that is-
27 C: [ye:ah.
28 C: >that's what I'm kind of thinking I don't< (0.8) like
29 (0.8) yeah sure I can come up with like reasons and stuff
30 like that but (.) it's not as like an over encumber:ing
31 (.) [piece of-
32 T: [yeah,
33 C: kind of- (.) dramatic part [of my history that has
34 caused=
35 T: [yeah,
36 [no.:
37 C: =me to feel like shit like?
38 T: so it's kind of (.) a bit (.) being able to identify what
39 is actually going on.
40 C: yeah,
41 T: and how you can then change [that a little bit.
42 C: [yeah,
43 C: >pretty much I guess? [yeah, ¶heh
44 T: [s:o. put like (0.5)
45 <identification>?
46 C: ↑ye[ah ¶hehuh
47 T: [and <identifying> what's going on?
48 ((T writing))

The therapist begins by continuing a previous goal setting activity, asking if the client would like to create a goal in addition to those already set. The client in line 2 presents misaligning responses including laughter, before expressing difficulty in performing the activity. The therapist at line 7 accepts the client's proposed relevancy of 'feeling less crap', deciding this as relevant information for the activity over the client's suggestion of multiple difficulties referred to as 'a thousand things'. The client at line 9 again presents laughter but also downgrades their authority to be able to answer their therapist's questions. This continues in the client's next turn where they give evidence for their lack of knowledge authority, followed by an overt expression of their difficulty in selecting a goal (lines 17-20). The therapist at line 22 offers a list of candidate answers for the client. This list leads to a presentation of another candidate answer from the therapist. The client affiliates with the latter candidate answer and aligns the activity in lines 28 to 31. The client also gives evidence for the appropriateness of the therapist's goal suggestions. Both parties construct and accept relevancies proposed by the other for the remainder of the extract, working together to agree on a goal decision.

The therapists' scaffolding in these instances served to realign clients and assist with any difficulty in taking part in the goal negotiation. The therapists also offered suggestions based on prior content and local content. These were presented as both single suggestions or lists of candidate answers. The therapists also employed questions with an increasing focus on clients' knowledge authority to answer those questions. At times, therapists used epistemic downgrading alongside these questions to recruit an answer from the client. For example, in a continuation of extract 1a, extract 2d shows a therapist using scaffolding after an initial goal suggestion from prior content.

Extract 2d

Dyad E assessment session, 79 minutes

1 T: er:m (1.7) but so that we can sta- see where you are now
2 and this is also part of our outcome measures and see
3 where yo:u (0.7) you get t:o.
4 C: yeah,
5 T: er:m (1.7) but if you wer:e (0.7) I mean you don't have
6 to do al- (.) a:ll of them. but if you were to pick (1) a
7 fe:w things what (0.8) do you think (1.5) would be
8 beneficial [for y]ou to get out of-
9 C: [.h]
10 T: w[ha-]
11 C: [erm] ↑[hehaha.
12 T: [I guess what I'm asking i:s
13 C: yeah,
14 T: people normally come to therapy because they want some
15 kind of change.
16 C: yeah,
17 T: and whether that's relie:f (.) from (0.4) the mood that
18 they're in or (.) or behaviour that they're seeing (0.5)
19 erm or whether it's to f- (.) find someone to listen to
20 them and find a way to cope. (0.7) er:m.
21 C: yeah,
22 T: and I mean these aren't [we can change these?
23 C: [I know >yeah yeah yeah yeah< erm
24 (0.7) yeah I- just weird (0.4) like don't know how to (.)
25 phrase it or word it if that makes sense li:ke.
26 T: ↑well it-
27 C: ↑heheha.
28 T: just give me something and [then we'll see if we ca:n (.)
29 look at it together.
30 C: [er:m
31 C: yeah I- (0.7) I guess just kind of (2.1) being able to
32 function (.) a bit (.) easier

The therapist frames the goal setting activity as having flexible parameters (line 5). The client misaligns with the questioning from the therapist by laughing at line 11 rather than offering an answer. Therefore, suggesting a problem with the question that the therapist then choses to rephrase. The therapist offers an account and justification for the question, as well as gives a normative dimension to the activity across lines 12 to 15. The client does not engage with the activity at line 16. This lack of engagement leads the therapist to provide a list of candidate answers (lines 17-20). When the client demonstrates further difficulty through the nervous laughter at line 27, the therapist suggests that any answer given by the client would be appropriate for progressing the activity.

Therapist scaffolding following client misalignment

Three extracts showed one client presenting continuing, misaligning responses that their therapist followed with attempts to recruit the client into a goal setting activity. Extract 3a demonstrates how the therapist encouraged the client to set a further goal.

Extract 3a

Dyad A assessment session, 61 minutes

1 T: alright? (0.9) and let's go for a thi:rd (.) er (.) goal
2 erm (0.7)°to° see if we can
3 (1.1)
4 T: erm get a third one down. (0.7) anything else that kind
5 of stands out for you?
6 (7.2)
7 C: nothing I can think of.
8 T: no? (0.9) <I wonder if it might be> thinking just to your
9 question:naire, (.) where is it? (7.7) in terms of this
10 one. (0.6) feeling bad about yourself. if we were >to<-
11 to maybe work on that (1.1) erm (0.8) would that help you
12 to feel better? (2.9) possibly
13 C: possibly
14 T: possibly (0.6) yeah, erm. (1.4) ((shuffling papers))
15 (3.3) and if you were to feel better about yourself what
16 would that look like?
17 (3.3)
18 ((start of writing))
19 (6.1)
20 C: °I don't know.°
21 (2.3)
22 T: ((end of writing)) that's ok:ay, er:m. (0.9) so sometimes
23 some people say that that might be that I: (1.9) I feel
24 more confident o:r I feel like I: like myself better than
25 I: (.) previously di:d or that I: improve my self-este:em
26 (27.9)
27 T: not sure,
28 C: °I'm not [sure°
29 T: [nope? (.) that's okay (.) why don't we just
30 leave it at that then (.) erm (.) with what we've got
31 written down here to feel better about myself and that's
32 something that we can revisit potentially if you come
33 back (1.0) yeah? .h but what would the rating for that
34 be?
35 C: not °at all°.

The therapist's first turn is a suggestion to set a third therapy goal. The therapist provides gaps for the client to respond at the pauses in lines 2 to 4. They

continue providing this space for the client beyond the first transition relevance place at the short pause (0.7) in line 4, finishing with a direct question at line 5. The client chooses not to take a turn at any of these transition relevance places. The therapist treats the client's lack of a response as authority to move forward with setting a third goal. Following a long pause at line 6, the client responds to the therapist's question but misaligns with the goal setting activity.

The therapist pursues the goal setting activity in line 8 after receiving the client's response of 'nothing I can think of'. The therapist does so by proposing a suggestion drawn from on the client's prior questionnaire responses (line 9). As such, the relevancies proposed include the client's responses. However, these responses are constrained by a numerical scale to fit the questionnaire item. Throughout lines 9 to 12 the client does not take a turn; and the therapist continues to suggest a goal based on the questionnaire response. As the client again chooses not to respond in the therapist's pauses, the therapist asks a direct question (lines 12-13).

Following the client's silence at line 13, the therapist proposes a candidate answer. The client affiliates with the therapist's candidate answer, repeating it. However, the client also shows a lack of certainty about the answer through their emphasis at the end of the word 'possibly' and the minimal nature of this answer. The therapist repeats the candidate answer at line 15 and takes the client's minimal engagement as permission to continue. After a pause at line 16 with no turn from the client, the therapist provides a direct question asking the client if they felt better about themselves, "what would that look like?" (line 16). Using this direction question indicates to the client that a response is required. This question is met with further silence. Therefore, the therapist follows this silence by beginning writing,

which may be onto the Goals Form or another form of note-taking. Throughout the extract, the client does not explicitly agree nor object to the proposed goal.

After a silence during the therapist's writing, the client displays a lack of knowledge authority at line 21. The client responds quietly and emphasises their lack of authority or confidence in giving an answer. The therapist at line 23 accepts the client's not-knowing response. In doing so, the therapist is performing an action similar to an apology acceptance.

The therapist then continues their pursuit of the goal by refining their suggestion drawn from the clients' questionnaire response. The therapist offers less space than previously for the client to have input. Instead, they list options for the client that are framed as what others might have chosen. At line 26, the therapist ends their turn without directly deferring to or inviting the client to be the next speaker, but instead leaves this open. There is a long pause at line 27, indicating the client is having difficulty in producing a turn. The therapist offers a candidate answer at line 28, which the client again affiliates with and repeats quietly with no expansion. Line 30 sees the therapist offer reassurance after the client's answer. The therapist then suggests a termination of the goal setting activity, although suggests the activity is incomplete and to revisit the activity later, again offering a candidate answer at line 30.

Extract 3a demonstrates a defining feature of this category; the therapist employing scaffolding following the client's continuing misalignment. Within this and similar extracts, the therapist created the first pair-part and regularly provided gaps in their speech. These gaps provided opportunities for the client to respond. However, the client shows little or no attempts to produce a turn at these points. For these extracts, the therapist employed scaffolding using prior content to further a

goal setting aim. Within this scaffolding, the therapist used the provision of accounts and candidate answers as the client's misalignment continued.

Alignment is not repaired throughout the extracts, despite the therapist's attempts to do so by referring to the client's prior responses. When faced with continuing misalignment from the client, the therapist sets up the relevancies for the goal decision to fulfil the aim of the goal setting activity. These relevancies are set up without much contribution from the client. As such, the therapist relied on minimal agreement or a lack of objection as permission to continue. The relevancies were created using prior content from the client earlier in the therapy session. In extract 3a this consisted of numerical answers to an outcome measure. The client gave non-committal responses or showed minor acceptance to therapist's suggested relevancies. However, these responses could also be either acknowledgement or an understanding of the therapist's speech, rather than acceptance. The final goals are constructed using the therapists' words, although in extract 2a the therapist suggests the goal setting activity to be incomplete.

One extract contains unique actions from the client compared to the other extracts within this way of conducting goal negotiations. Extract 3b is from an earlier discussion from the same dyad as Extract 3a, and shows the client trying to realign with the therapist and the goal setting activity. Immediately preceding line 1 of extract 3b was the creation of another goal from this dyad with an absence of talk where the previous goal was likely being written onto the Goals Form.

Extract 3b

Dyad A assessment session, 59 minutes

1 T: h .h and then if we were to think about say your s::leep
2 is a particular difficulty (0.8) °yeah°? (0.9) is that
3 something that you would want to use these sessions to
4 work on? or not?
5 C: umm (4.8) maybe, I'm not entirely sure how counselling
6 will help me sleep though,
7 T: mhm (.) mhm (.) .h so will we put that down potentially↑
8 yeah (.) okay (.) >as- as a< may:be is to erm ((writing))
9 improve sleep oops
10 ((writing))
11 T: and what would that look like? if you were to improve
12 your sleep how would you know it was (.) improved?
13 C: Erm, (1.9) being able to sleep more than a couple of
14 hours at a time erm, (.) finding it easier to get to
15 sleep (.) maybe not feeling so tired all the time.
16 T: perfect that's a really good example yeah, er:r and how
17 much do you think you've achieved that?
18 C: erm (2.1) mm maybe two with the help of sleeping pills.
19 T: with the help of the sleeping pills.
20 C: >I only really< take them if I have to do something the
21 next day though.
22 T: okay (.) alright,.hh

The therapist begins extract 3b by suggesting a goal focus based on prior content. This prior content was previously spoken by the client, rather than the questionnaire responses as seen in extract 3a. The client at line 5 then questions the relevance of this suggestion to the current treatment context. The therapist minimally accepts the goal suggestion at line 7 and as with extract 3a, suggests a potential goal for later use. This suggests the therapist is trying to balance the institutional requirements to create appropriate therapy goals, with their affiliation with the client's querying of the appropriateness and non-commitment to the suggestion. The goal setting activity is concluded following the writing down of the goal at lines 8 to 10.

The therapist reopens the goal discussion at line 11, following the writing down of the goal. The client tries to realign by adding supporting evidence to the previous goal suggestion. The therapist at line 16 acknowledges the client's response

and their attempts to realign. However, multiple suggestions are acknowledged as one. This encourages the client to answer the therapist's question in a similar format, selecting whether to answer based on their suggestion for 'being able to sleep more', 'finding it easier to get to sleep' or 'not feeling so tired all the time'. This restraint to the client's answer suggests that two of the three answers they gave may not be relevant to the goal setting activity. The therapist subsequently presents a new first pair-part and moves the topic of talk onto the rating of the goal.

Clients leading the establishment of relevancies for the goal negotiation

Five extracts showed that clients can take a leading role in establishing goal relevancies, following alignment from both parties. Therapists in these instances adopted a reduced role in the goal negotiations, as can be seen in extract 4a. For extract 4a, the preceding two minutes of talk contained the therapist asking the client how they are progressing towards goals and whether they wanted to adjust those goals.

Extract 4a

Dyad B session 10, 2 minutes

1 C: so I was like fmaybe I should re:st? heh instead of
2 taking a lea:vel (0.4) heha 'and' so I think I've been much
3 better with that, (1.0) er:m
4 T: yeah it really does look like with all the goals that you
5 set,
6 C: fyea:h
7 T: are kind of [(move) towards that
8 C: [fyeah yeah yeah yeah yeah
9 T: and the- you know one option here is that we don't
10 particularly have any goals it's [just
11 C: [muh
12 T: a space where you [can kind of
13 C: [yeah I think right no:w I think right
14 now that's a good yea:h- n- (.) I don't really unless I
15 think of something that I really want [to.
16 T: [yeah,
17 C: yea:h right now cause .h I have right now like (.)
18 professional goals I guess? like I want to (1.5) I have
19 like a fe:w (0.9) symposium where I would like to present
20 my wor:k (0.4) so it's more the goals I got like
21 organising myself you know writing an abstra[ct
22 T: [yeah.
23 ((cough))
24 C: submitting the abstract .h getting those presentations
25 together those topics, as I contin[ue to do (0.6) (.h) erm
26 T: [yeah.
27 C: you know working on my cv and applying for different jobs
28 and see. (0.9) .h s:o.
29 (2.1)
30 T: >I [thi-<
31 C: [I think applying (0.6) what I've learned through
32 these months to that
33 T: mhm.
34 C: is going to be my rea:l goa:l, heheHAhahe yeah.
35 T: so I mean maybe it's a period of just kind of
36 consolidating what we've (.) learnt [here
37 C: [fYea:h
38 T: and looking at how [that applies and what's going on in
39 C: [fyea:h yea:h

The client in lines 1 to 4 offers evidence for their therapy goal progress and the therapist affiliates with this. This continues until line 8 when both have established that the client's goals reflect their desired progress in the therapy. There is an overlap at line 7 where the client emphatically accepts the therapist's affiliative response to their speech. This overlapping reoccurs throughout the extract. The therapist continues the goal negotiation in line 9, creating a suggestion and new

relevancy. The therapist is interrupted by the client in line 11 but continues by showing they had not completed their turn. The client displays affiliation and alignment from lines 10 to 16 by overlapping the therapist's speech and showing agreement with the therapist's suggestions.

At line 17 until 28 the client gives an extended three-part list to justify the appropriateness of focusing on their professional goals over any personal goals. During these turns the therapist mostly offers continuers. Despite the suggestion of further goals from the client at line 20, the therapist does not take up these as relevant to the goal negotiation. This is predominantly as the client has already determined these to be professional goals rather than personal or therapy goals. Therefore, the client at line 24 continues to present their academic goals. In doing so, the client chooses to remain on their topic when the therapist tries to produce a turn at line 30. As such, the client is deciding the relevancy for this information within the goal negotiation.

The client at line 31 proposes a goal based on their previously suggested content of moving forward with professional goals. Here, the client is expanding and emphasising their previous suggestion and therefore increasing their authority to define the negotiation. In presenting this suggestion the client emphasises the notion of applying their learning. The client also reaffirms their suggestion explicitly at line 34. The therapist summarises a suggestion over lines 35 to 39 based on both parties' suggestions, although determined by what the client has selected to be relevant. In this way, the therapist has provided an upshot formulation of the client's talk information, that the client emphatically accepts in lines 37 to 39.

Within the five extracts that followed this trajectory, clients and therapists aligned in the goal setting activity at the start of extracts. However, the clients were

predominantly channelling the talk and introducing relevant information. These clients provided suggestions unprompted by their therapists. Yet, there were also instances of therapists asking questions to clarify or further explore clients' suggestions. Within these extracts, therapists have minimal time to contribute to the talk, with the clients often overlapping with therapists' speech. In these instances, clients emphatically accept therapists' summaries of proposed relevancies. These clients demonstrated their authority and confidence in making goal decisions through their overlapping speech, extending their turns beyond transition relevance points, and repeating their goal suggestions. The clients continually reinforce the relevancy of their initial suggestions by presenting evidence and building a collection of cases for why that suggestion should be a part of the goal decision. The therapists accept clients' proposed relevancies and subsequently present summaries of those relevancies or continuers. In a limited number of instances, when therapists would offer suggestions to try to co-construct the goal relevancies, the client often does not accept these. Both clients and therapists expressed agreement of the final goals that were often phrased using clients' words.

Extract 4b

Dyad C assessment session, 38 minutes

1 T: and <now if- do you have go:als for yourself.> (0.9)
2 other goals (0.5) or other ideas of (2.5) what you would
3 want to work on (0.5) in our >time together?< (0.7) here.
4 C: er:m (2.7) I don't know really kno:w. (2.8) (I don't)
5 (3.8) (I really don't) (3.6) to feel better? fhehuh.
6 T: yes.
7 C: yeah. (eventually).
8 T: fhm.
9 C: er:[m
10 T: [how would that look like for you?
11 C: er:m (2.4) finding ways of feeling better about myself
12 (.) er- (.) my (.) appearance (.) the way I think the way
13 (0.7) you know (.) my (1) intelligence,
14 T: >m[m
15 C: [just generally feeling better about myself.
16 T: fmh:[m.
17 C: [er (1.3) yeah (0.4) and being able to get (.) out
18 (0.4) of bed in the morning.
19 T: fm:[m
20 C: [just (.) do the da:y, doesn't matter what (0.7)
21 happens in the day I can get to the end of it.
22 T: fhm.
23 C: kind of in that- (0.6) cause that's just not happening at
24 the moment.

Extract 4b presents a variation to the way clients adopted a leading role following alignment between both parties. Following a query for additional goals from the therapist (lines 1-3), the client displays difficulty in proposing concrete suggestions for the goal decision. This difficulty is displayed through their pauses and presenting of their suggestions as questions (lines 4-5). The therapist encourages the client to proceed with their suggestions through continuers (Lines 6-8), before probing for a further refinement in line 10 of the client's suggestion. The client answers this probing question at line 11. The client displays less difficulty in answering this question, as seen by their shorter pauses and less questioning intonation. This continues for the remainder of the extract, with the therapist again offering continuers. The therapist's actions in this extract demonstrate that although their verbal input can be quite minimal, they can still help progress the goal setting activity. In doing so, the therapist is prompting the client to elaborate. As such, the

therapist demonstrates their active listening and support for the client, as is recognised within person-centred psychotherapy practice (Fitzgerald & Leudar, 2010).

Discussion

This analysis showed three trajectories that goal setting negotiations followed. First, by aligned clients and therapists co-constructing the relevancies for goal decisions. Second, by therapists using scaffolding, prior content, accounts, and candidate answers following continuing misaligning responses and minimal engagement from the client. This second trajectory resulted in the therapist adopting a leading role in the goal negotiation. The last trajectory consisted of clients adopting a leading role in setting up the goal relevancies after the therapist had introduced the activity. Clients and therapists co-constructing the relevancies for goal decisions was preceded at times by an initial repair of alignment in goal setting. Such repair was achieved through therapists' scaffolding using similar methods to the second trajectory. However, this latter scaffolding was also inclusive of local content suggestions and therapists' questions being increasingly dependent on clients' knowledge.

Alignment

The three trajectories that goal negotiations followed were influenced by the alignment or misalignment between dyads. Across these three trajectories, alignment occurred at either the introduction of the goal setting activity, later in the activity, or not at all. This alignment influenced: the amount of scaffolding that the therapist used; who adopted a lead role in setting up the relevancies for the goal decision; how much overlapping speech occurred; and how much silence each participant left for the other to respond.

Alignment can be key for psychotherapy goal decision-making as it enables participants to successfully accomplish the activity. Heritage (1984) states that an interaction's participants can establish intersubjective alignment by managing the talk together. Participants achieve this through coordination of turns, drawing on methods to overcome difficulties of understanding, and performing organised sequence actions such as question-response sequences (Sacks et al., 1974; Schegloff & Sacks, 1973). As such, Schegloff (2007) notes that alignment helps participants work towards beginning or meeting interactional agendas and projects. In the context of the current analysis, meeting a project through alignment could be a decision to create a goal, amend an existing one, or to not work with goals.

When there was misalignment between dyads in the current data, one participant would often continue to pursue their agenda until alignment was repaired or the activity concluded. For example, therapists who adopted a lead role in setting up the goal relevancies did so when a client chose not to engage or respond. Within this process the therapists continually try to explore what the client wanted to achieve from therapy. However, the clients resisted this plan for the talk. They did so through using silence, declarations of a lack of knowledge authority, or in one instance an explicit statement querying the validity of a goal suggestion.

Muntigl and Horvath (2014) present psychotherapy data with displays of disaffiliation and misalignment similarly to the present study. They showed that each of their participants would try to pursue an individual agenda, rather than pursue a common one. Muntigl and Horvath liken these instances to a battle over who has primary rights in deciding the trajectory and content of the talk. Such battles are evident in the current data corpus. These instances also include asserting who has the knowledge authority to decide the goal or who the goal content should come from.

As such, the examples of misalignment in the current data can be likened to a battle between the clients offering a lack of knowledge authority to progress the goal negotiation, and the therapists' repeated attempts to place more of that authority on them. Such instances contrast with Rogers' (1942; 1995) assertion for treatment of the importance in client's engaging with and offering talk. This misalignment in the current analysis also contrasts with the eligibility criteria for the CREST Research Clinic of a client having and being willing to work on an aspect of their life they wanted to change. However, clients in the present analysis were likely expressing difficulty in discussing topics during goal negotiations, rather than a lack of a willingness to take part in psychotherapy. For example, one clients offered the following report during their previous Interpersonal Process Recall interview: 'and then I had everything in my life to suddenly think about goals for. That would have just been so much' (Chapter 4, I258-260).

Scaffolding

The present analysis showed how therapists used scaffolding during misalignment to encourage clients to engage in goal setting activities. To encourage client responses, therapists used scaffolding that included: suggestions based on prior or local content; single or lists of candidate answers; epistemic downgrading, and explicit invitations to clients to offer a suggestion. At times clients did not respond to therapists' scaffolding, although alignment was repaired in most instances and the dyad completed the goal activity. Within this process, therapists produced questions that were dependent on their client's knowledge. Therapists phrased their questioning to be increasingly dependent on their client's knowledge each time that client offered a lack of knowledge authority or did not respond at a transition relevance point.

The present analysis was preceded by Cantwell (2017), who examined a similar collection of pluralistic therapy data from a different site. Cantwell (2017) examined therapists' use of questions about what might be helpful. Cantwell provided evidence that when therapists talk to clients about what might be helpful in treatment, those therapists may need to move between treating the client as potentially unknowing and potentially knowing by leaving space for clients to offer a contribution. Such findings share similarities with therapists' suggestions and questions in the current data. For example, therapists at times produced suggestions or candidate answers when clients chose not to fully engage or produce a turn. Yet, therapists also left gaps in their speech or requested a client's thoughts on a suggestion. When clients experienced continuing difficulty, therapists would voice an unknowing stance to defer to a client and frame the answer as dependent on a client's knowledge.

A therapist requesting a client's thoughts on suggestions during the scaffolding can be likened to the action of *checking out* (Rennie, 1998). Checking out consists of a therapist questioning the accuracy of their talk with a client, being open about their strategies or intentions, or inviting the client to focus on their own plans (McLeod & McLeod, 2011). Such actions have been suggested to contribute towards positive outcomes for talking through difficult issues or problems (McLeod & McLeod, 2011). Each of these actions can be seen in the current corpus and at times resulted in clients responding and engaging with the goal setting activity, enabling both parties to complete the activity together. McLeod and McLeod (2011) describe the importance of checking out and other types of metacommunication when a relationship or topic shifts during talk. This would be applicable to the present study's goal setting context where clients had been detailing their history and

difficulties before the therapist introduced the activity of organising these difficulties into a goal.

Turn taking

Across the three trajectories for negotiating goals, clients and therapists performed their turns and encouraged or discouraged turns from the other participant in different ways. When misalignment was present, all therapists within the three trajectories provided opportunities during or at the end of their turns for clients to respond. When both parties were aligned there was either a steady flow of responses between participants or an overlap of speech, although such overlap was often from clients who produced affiliative comments in response to their therapist's speech.

Schegloff and Sacks (1973) offer that talk between two participants tends to occur as an exchange of responsive turns. Turns in the current data include questions or suggestions that would require specific responses, such as an answer to a question or an acceptance or refusal of a suggestion. Therefore, there would be an expectation that when one participant ends their turn, the other has increased responsibility to produce a turn themselves (Schegloff, 2007). This makes clients' choice to not respond at transition relevance points interesting as there would have been the pressure to respond when the therapist had finished their turn, question, or suggestion. Moreover, the pressure to mobilize a response can differ depending on the design of the previous turn completed by the therapist. For example, Stivers and Rossano (2010) offer that the amount of response pressure can be influenced by the question turn design features of: how narrow a question's focus or topic is; the amount of rising intonation from the speaker; whether the speaker's gaze is directed at the recipient or not, and the recipient's epistemic expertise on the topic in comparison to the speaker. The latter of these design features can offer an

explanation as to why clients may not have offered a response, as clients had come to therapy to seek help for their difficulties and may need additional guidance in how to tackle them. Extracts where clients do not offer responses are also similar to instances presented by Lindstrom and Weatherall (2015). Within these, Lindstrom and Weather showed that patients' lack of responses to their practitioners' turns or suggestions were a method to offer resistance. However, further investigation is needed to determine whether the resistance in the current data corpus was due to a lack of knowledge, or whether this was a preference to not contribute to the discussion at hand.

The present study's findings from interactions between two individuals may differ for analyses within group settings. Interactions between pairs have increased pressure for the other participant to provide a response at a transition relevant point or if the other participant ends their turn. In a group setting there would be opportunities for self-selection of turns, or to not take turns (Schegloff, 2007). As such, the observable actions performed by participants may differ in psychotherapy groups compared to pairs. This is due to there likely being a reduced pressure in groups to offer a response, as another participant could self-select if a participant had difficulty producing a turn. Self-selecting in these group circumstances would also be a good indicator of engagement with the goal setting.

Therapists in the present data used declarative questions prefaced with 'so' to make suggestions based on their client's local content. These questions occurred when dyads were aligned or not. However, such questions were predominantly used in response to a misaligning response from the client. These responses consisted of laughter, a quietly spoken 'I don't know', or a long silence following a therapist's question or suggestion. Therapists' also used declarative questions when clients

questioned the appropriateness of their suggestions with their therapist. Thompson et al. (2015) showed that the use of declarative questions from psychiatrists in outpatient consultations predicted better treatment adherence and perceptions of the therapeutic questions. These psychiatrists also used declarative questions to demonstrate their understanding of clients' emotions towards the topic being discussed. Thompson et al. also noted the use of questions prefaced with 'so' within psychological contexts can be used in displays of empathy towards the other participant. Thompson et al. give examples of declarative questions to query patient concerns, such as 'so you feel a bit anxious'. Similarly, the examples in the current data of therapists' declarative questions also serve to channel the goal negotiations. For example, 'so I mean maybe it's a period of just kind of consolidating what we've learnt here' (Extract 4a, line 35), and 'so actually maybe it's kind of trying to figure out why you do feel so crap and what that is' (Extract 2c, lines 19-20).

Relevancies

Participants used two types of information to construct goal negotiation relevancies. First, by using prior content information that was previously discussed or considered to be relevant by participants earlier in the therapy session or in a previous therapy session. Second, by using local content information that was presented earlier in the extract. Both types of information could have similar content, such as a difficulty or problem a client was seeking therapy for.

When clients and therapists experienced misalignment, the relevancies for the goal negotiation were initially suggested by the therapist and based on prior content from the client. If this misalignment continued, the relevance of the information was decided by the therapist. At these times, there was no explicit objection from the client that the proposed information might be irrelevant to their goals. In these cases,

the clients displayed agreement with the final goal. However, this agreement was minimal and could also indicate acknowledgement or an understanding of the therapist's speech.

When clients and therapists were aligned in a goal-setting activity, either the relevancies were co-constructed by the therapist and client, or the clients took a leading role. When both parties co-constructed the goal relevancies together, initial suggestions were often from the therapist and based on prior content from the client. In these instances, both parties presented and accepted each other's suggestions and displayed strong agreement for the appropriateness of the final goal. When clients took a leading role, therapists accepted the information proposed by the clients as relevant. Clients' suggestions in these instances referred to both prior content and local content. However, the therapists would then adopt a confirmatory or reflective role within the negotiation. For example, by presenting displays of acknowledgement or continuers. Although therapists chose to accept clients' suggestions as relevant, clients did not always accept those suggested by their therapist. Both parties agreed on the final goal. However, therapists' displays of agreement when clients were taking more of a lead were stronger compared to clients' displays when therapists took more of a lead.

Participants constructing and deciding what information is relevant within a goal negotiation is fundamental for reaching a goal decision. Wilson and Sperber (1981) note that participants in focused talk-in-interaction work together towards a common focus and share a common definition of that situation. In doing so, participants will accept information presented by themselves or others as relevant to that common focus or for fitting the common definition. Werth (1984) proposes that a "remark is relevant if and only if it is related to the purpose of the conversational

goal” (p. 55), with each participant seeking to add content and propositions that are relevant to and can build upon this. Therefore, clients and therapists would need to assess their own and other’s suggestions for relevancy to achieve a goal decision. For example, one therapist proposed to work with goals in a new way: ‘one option here is that we don’t particularly have any goals it’s just a space where you can’ (Extract 4a, lines 9-12). The client then built upon that suggestion with: ‘yeah I think right now I think now that’s a good yeah, I don’t really unless I think of something’ (Extract 4a, lines 13-15).

In the present data, therapists and clients often commenced a post-decision discussion after mutually agreeing a goal. The occurrence of these discussions was minimal when clients and therapists were not aligned, but still evident. For example, one client proposes new content as relevant for a goal decision after an agreement is made, although this information is not discussed further: ‘I only really take them if I have to do something the next day though’ (Extract 3b, lines 20-21) that is acknowledged by the therapist ‘okay. Alright.’ (Extract 3b, line 22). Therapists and clients in the post-decision discussions tested the fit of the goal for meeting clients’ needs. In these instances, the clients provided additional evidence as to why the goal fits their circumstances and needs. As such, the post-decision discussions could serve two functions. First, for therapists to ensure that the goal decision is the correct one and to their speech with clients. Second, to suggest that the goal decision is considered incomplete by one participant, despite having been agreed by both. For example, one client and therapist who co-constructed their relevancies re-opened the goal negotiation to discuss an expansion of previously discussed evidence. Included was also information from the client about why the goal needed to be present and an expansion of evidence to include a similar difficulty. This new evidence did not

change the goal, but the client's choice to present this indicates that they felt the fit of goal would not be understood if they did not present this additional information.

The post-decision discussions share similarities to Park, Goode, Tompkins, and Swift's (2016) case examples of shared decision-making in psychotherapy. They suggest that similar occurrences could be evidence of a shared decision-making process within psychotherapies. Park et al. showed instances of clients adding additional information immediately after both therapist and client had agreed a course of action. In these turns, the clients offered additional preference information or evidence as to why they have agreed to course of action.

Limitations and future directions

The data available within the current collection is limited to audio recordings only, limiting observations of non-verbal actions. These actions have the potential to display actions of agreement or disagreement contributing to decision-making negotiations such as a nod, shrug, or shake of the head. For example, in extract 5a the therapist is finalising a goal decision and suggests revisiting the decision later. In line 3, the therapist offers a candidate answer following a pause. This answer could be in response to the client's lack of response or to a non-verbal cue from the client.

Extract 5a

Potential client non-verbal behaviour

```
1  T:   written down here to feel better about myself and that's
2       something that we can revisit potentially if you come
3       back (1.0) yeah? .h but what would the rating for that
4       be?
```

Difficulties in identifying non-verbal behaviour also occurred when sounds of writing occurred during a goal negotiation. This could have implications for when and how a decision is made, as the act of writing the goal onto the Goals Form can

cement the decision. In extract 5b the slowed speech from the therapist alongside the sounds of pen scratching in line 3 are likely to suggest that the therapist is writing. However, it is unclear whether the therapist is writing the spoken words onto the goals form, or whether they are recording notes elsewhere. Collecting video recordings alongside audio would help to remove difficulties to identify these non-verbal actions that could have implications for goal decision-making.

Extract 5b

Potential therapist non-verbal cue

1 C: [no.] slow do:wn. (.) yes. (.) being able
 2 to slow down (0.9) the pa:ce. (1.2) °yeah°
 3 T: yeah ((writing)) <be able to sl:ow do:wn> yeah, [that's
 4 C: [probably

The present analysis sought to only describe the decision-making process within goal negotiations. As such, the extracts in the corpus were not judged for their amount of shared decision-making. However, goal decisions where aligned clients and therapists co-constructed the goal relevancies could be likened to existing definitions of shared decision-making (Coulter & Collins, 2011). This contrasts with the remaining two trajectories for goal negotiations, where either the therapist or client contributed more content and maintained more authority over the relevancies. Yet, these latter instances of decision-making could still be shared, although led more by the client or therapist (Cooper & McLeod, 2011; Towle & Godolphin, 1999). Future studies could examine data sets containing decisions other than goals to see if the trajectories for performing goal negotiations could be supported or expanded upon with regards to any similarities with shared decision-making. Such examinations could also help develop an understanding of the relationship these trajectories might have with psychotherapy outcomes.

Clinical implications

The current analysis demonstrated that different methods are available to therapists if a client shows difficulty engaging or responding within a goal negotiation. First, the activity can be halted or returned to at another time. Second, a therapist can attempt to progress the discussion and encourage a client's involvement. To do so, therapists can draw on scaffolding using prior and local content suggestions, candidate answers, epistemic downgrading, and explicit invitations for clients. This scaffolding can help dyads to move towards a shared decision-making process that would require deliberation and discussion before both parties reach an agreement. If clients display continued difficulty within the activity, therapists could use epistemic downgrading to further encourage the client to engage with the decision-making process. In doing so, therapists can assist clients that are having trouble contributing to the decision-making process to offer their opinions and suggestions. Doing so can help facilitate a shared decision-making process.

Therapists should be aware that clients may present new information or evidence after a goal decision appears concluded or is written down. Extracts in the present study show that post-decision discussions included additional evidence for the appropriateness of the decision for meeting the client's therapy needs and preferences. However, the possibility exists that a client could offer information contradictory to the decision made. Such new information could change the fit of the goal to meet the client's needs and the therapist's professional opinion of that goal. Therefore, it may be useful in moving towards a shared goal decision to consider initial goal agreement between both parties as confirmation of an appropriate way to progress the negotiation. If any post-decision discussions then occur that do not contradict the that goal, then the setting activity can be confirmed as complete.

The post-decision discussions could also suggest that one party sees the goal as unfinished. Instances in the present corpus show participants adding information after an agreement that further accounted for the goal (Extract 2b, lines 55-62). However, this additional information at times also consisted of conflicting information that suggested the speaker did not see the decision as satisfactory (Extract 3b, lines 20-21). Therefore, despite displays of alignment and agreement from both parties during goal setting, there may be some implicit disagreements with the goal. Muntigl and Horvath (2014) recognise that alignment from both parties does not necessarily imply agreement, as both parties can cooperate with each other to achieve an aim even if disaffiliation occurs. Therefore, therapists striving to work with shared decision-making could be aware of leaving a space for these post-decision discussions to occur. These discussions could be initiated by explicitly inviting the client to take part in a post-decision discussion, asking if they would like to add to or make the goal decision more appropriate for their needs. In doing so the dyad can work towards a shared goal decision that could be considered the best fit.

Conclusion

Goal negotiations within pluralistic therapy for depression followed three trajectories across six dyads. The present analysis showed that when alignment or misalignment occurred, therapists and clients each performed different kinds of actions. These actions included the use of: therapists' scaffolding of goal content in instances of misalignment; post-decision discussions; and either client or therapist predominantly deciding the relevancies for goal decisions, or both working together to co-construct these. Performing these conversational methods can influence the contributions and amount of involvement from both parties in the decision-making

process. As such, there is the potential for these methods to direct the goal negotiations towards becoming more therapist-led, client-led, or equally shared.

Chapter six: The association of shared decision-making with pluralistic therapy outcomes

Chapter six will further the understanding of how shared decision-making can be equally shared by a therapist and client, or led more by one party. To do so, this chapter contains the design and evaluation of a shared decision-making observation scale. Ratings from this scale will be used to investigate any relationship between shared decision-making and psychotherapy outcomes.

Research examining shared decision-making within healthcare and mental health literature can inform the likely impact of the approach within psychotherapy. For example, meta analyses showed shared decision-making interventions can be associated with: increased psychological and physical well-being (Joosten et al., 2008); increased patient satisfaction and participation (Duncan et al., 2010); more favourable patient adherence (Thompson & McCabe, 2012); and increased patient knowledge, reduced decisional conflict, and greater self-efficacy in disadvantaged patients (Durand et al., 2014).

Research examining shared decision-making interventions in mental health have shown the approach to be beneficial in mental health treatment. Samalin et al. (2018) reviewed the effects of shared decision-making interventions and decision aids on patients living with mood disorders. They presented evidence from randomised control trials in two primary care settings (LeBlanc et al., 2015; Loh et al., 2007), one outpatient setting (van der Voort et al., 2015), and one pharmacy routine practice setting (Aljumah et al., 2015). Samalin et al. (2018) reported that intervention groups compared to controls groups had: greater patient participation and satisfaction (LeBlanc et al., 2015; Loh et al., 2007); greater medication adherence and treatment satisfaction (Aljumah et al., 2015); greater patient and

physician comfort with the decision made (LeBlanc et al., 2015); greater overall functioning, and reduced depression symptoms at six months and 12 months (van der Voort et al., 2015). Samalin et al.'s. (2018) review offered new evidence suggesting shared decision-making interventions to be associated with favourable clinical outcomes. Together, these findings imply shared decision-making interventions have clinical, decision appraisal, and health management benefits in the treatment of mood disorders.

Client preferences in psychotherapies

Research examining the accommodation of a client's preferences can inform the understanding of the relationship between shared decision-making and psychotherapy outcomes. For example, Swift and Callahan (2009) and Swift et al. (2018) reviewed studies reporting the impact of client preference on treatment outcomes. Both reviews showed that accommodating for clients' preferences were associated with greater treatment outcomes and less likely to drop out of treatment than those clients not matched.

Kwan, Dimidjian, and Rizvi (2010) supports these meta analyses. Kwan et al. examined the effects of accommodating for adult clients' preferences within psychotherapy and antidepressant treatment. They reported lower working alliance scores in early stages of treatment for clients not matched to their preferred treatment, in comparison to those that were. Kwan et al. (2010) noted less session attendance from unmatched clients. Such clients had a greater likelihood of attrition by their final expected treatment session. Kwan et al. (2010) also showed an indirect effect for preference matching on severity of depression symptoms, mediated by session attendance. Together, these findings alongside Swift and Callahan (2009)

and Swift et al. (2018) provide comprehensive evidence for a positive effect of preference accommodation in psychotherapy on clients and their treatment.

A later meta-analysis by Lindhiem, Bennett, Trentacosta, and McLear (2014) supports the findings regarding preference accommodation. Lindhiem et al. (2014) reported evidence from 32 empirical articles across inpatients and outpatients with a range of diagnoses. Each article contained randomised assignment of either clients or clinicians. Clients that took part in shared decision-making showed increased treatment completion rates, compared to those who did not (Odds ratio = 1.37; Cohen's $d = 0.17$; $p < .001$). These clients also showed better clinical outcomes (Cohen's $d = 0.15$; $p < .001$) and greater satisfaction with their treatment (Cohen's $d = 0.34$; $p < .001$), compared to those who took part in shared decision-making.

Together, the findings of Swift and Callahan (2010), Kwan et al. (2010), and Lindhiem et al. (2014) indicate that decisions accommodating for clients' informed preferences are likely have a positive impact on those clients and their treatment. However, preference accommodation can also be part of informed-client decision-making models as well as shared decision-making models. Therefore, it would be useful to the field to understand whether shared decision-making can impact treatment, or whether this is limited to the accommodation of preferences alone.

Measuring shared decision-making

Healthcare and mental health research has designed shared decision-making measurement scales that could inform such measurement within psychotherapy. These scales include those completed from both patient and practitioner perspectives, as well as observation scales. For example, Edwards et al. (2003) designed the COMRADE tool. This is a patient-based outcome measure to gauge risk communication and decision-making effectiveness. The tool contains 20 items

informed by Elwyn et al.'s. (2000) shared decision-making competencies. Elwyn et al.'s. (2000) competencies suggest four steps to practicing shared decision-making: defining the problem and the agreement to be made; explaining that choice exists in the clinical content; presenting options and their associated risks; and moving towards a final decision or deferring the decision. The 20 COMRADE items gauge the effectiveness of treatment decisions using two subscales; confidence in the decision and assessment of risks. These subscales measure how much the decision-making process follows a shared, paternalistic, or informed-patient model.

Simon et al. (2006) demonstrated that no satisfactory patient-oriented measure existed for shared decision-making. They subsequently developed the shared decision-making questionnaire (SDM-Q). They draw on Elwyn et al.'s. (2000) and Makoul and Clayman's (2006) conceptualisations of shared decision-making to create an 11-item measure of patient perceived shared decision-making. Kriston et al. (2010) later developed the SDM-Q into a brief, nine item version and presented a factor analysis of a primary care sample's responses. This analysis showed evidence for the nine items contributing to a single dimension, suggesting an underlying construct. Scholl et al. (2012) later developed a practitioner version of the SDM-Q-9. This practitioner version adhered to the wording of the patient-oriented measure. They added additional items for how the practitioner felt they had behaved in the interaction, and how both practitioner and patient behaved together. Again, a unidimensional construct was found. Therefore, the SDM-Q measures are indicated to be appropriate for measuring shared decision-making from patient and practitioner perspectives. All three measures also showed excellent internal consistency. As such, the three SDM-Q measures would be useful for informing the construction of a new scale for psychotherapies.

Elwyn et al. (2013) later showed limitations still existed with shared decision-making tools. From cognitive interviews with patients, Elwyn et al. reported that some language used in shared decision-making tools and interventions can be unfamiliar to patients and act as barriers to the approach. They also indicated that this language does not account for patients who were not aware decision-making was occurring or needed to occur. Nor does the language account for patients not wanting decisions to occur. Elwyn et al. (2013) also suggested moving away from the terms ‘options’ and ‘preferences’, as their sample felt these can assume a willingness to adopt an active role in the decision-making process. Therefore, any new shared decision-making scale for psychotherapies should accommodate for these language limitations.

Observation scales of shared decision-making

Using observation scales to measure shared decision-making could accommodate for Elwyn et al.’s (2013) reported language limitations. One such tool is Elwyn et al.’s (2003) Observing Patient Involvement (OPTION) scale. This gauges overall patient involvement and shared decision-making in general practice and clinical consultations, as well as how much practitioners engaged their patients in the decision-making. This scale drew on Elwyn et al.’s (2000) competencies for shared decision-making. Elwyn et al. (2003) collected OPTION ratings for general practice consultations. They demonstrated the scale to have good internal consistency (Cronbach’s $\alpha = .79$) and strong inter-rater agreement (Cohen’s $k = .71$). Elwyn et al. (2003) concluded that the OPTION scale is appropriate for assessing how much practitioners involved their patients in the decision-making process.

Clayman, Makoul, Harper, Koby, and William’s (2012) observation instrument can also inform the design of a scale for shared decision-making in

psychotherapy. Clayman et al. (2012) built upon Makoul and Clayman's (2006) integrative model of shared decision-making to revise the Evidence-based Patient Choice Instrument and created the Detail of Essential Elements and Participants in Shared Decision-making (DEEP-SDM). Clayman et al. (2012) intended to counter limitations with existing observation scales that include: distinguishing between discussions around benefits and risks; accommodating for the durational and multiple discussion potential of some decisions; and recognising that some items in existing scales are rarely coded within data sets, such as assessments of patient understanding. To counter these limitations, Clayman et al. (2012) added an item category to reflect the ongoing decisions that can change throughout long-term care. They also included separate definitions within their coding scheme to distinguish between benefit talk and risk discussions. Last, they included instructions for raters to identify sufficient displays of confirming understanding from patients' talk. Clayman et al. (2012) further included a scale for the degree of shared decision making ranked from doctor-only (1) to patient-only (9). The DEEP-SDM was used to evaluate 150 video recorded decision-making segments across 80 decisions within breast cancer treatment consultations. Clayman et al. (2012) found the DEEP-SDM could successfully identify and code decision discussions for shared decision-making.

Despite the advances in shared decision-making measurement tools, Gärtner et al. (2018) showed the need for researchers to further develop both observation and self-report scales. They present a systematic review of shared decision-making instruments. Gärtner et al. showed that there was a lack of high quality measures currently available. They concluded that there was no gold-standard measure of shared decision-making. Given these findings and the requirement for an adapted

definition of shared-decision making for psychotherapy (Chapter 1), a new scale was developed specific to psychotherapy, rather than adapting an existing measure.

Research aims

The psychotherapy field would benefit from the creation of a scale to measure shared decision-making as no scale currently exists, nor a gold-standard scale identified for other contexts. This new scale will build on the development of the OPTION and DEEP-SDM that showed observation scales to be appropriate for measuring shared decision-making (Elwyn et al., 2003; Clayman et al., 2012). Developing such an observation scale would accommodate for limitations within patient-oriented self-report measures (Elwyn et al., 2013; Gärtner et al., 2018).

This new observation scale will be informed by the conceptualisations of shared decision-making used by existing instruments (Elwyn et al., 2000; Makoul & Clayman, 2006), as well as the adapted Coulter and Collins (2011) definition presented in chapter one. It will also be advantageous to the validity of a new scale to draw on the qualitative analyses in the present thesis (Chapter, 4; Chapter, 5). Moreover, items will be included to gauge shared decision-making on a scale from entirely therapist-led to client-led (Clayman et al., 2012).

Testing a new shared decision-making observation scale alongside psychotherapy outcome measures would enable comparisons with previous findings for the impact of shared decision-making. This would be true not only for the qualitative findings in the present thesis, but also for the shared decision-making meta analyses from other contexts (Duncan et al., 2010; Durand et al., 2014; Lindhiem et al., 2014; Samalin et al., 2018, Swift & Callahan, 2009; Thompson & McCabe, 2012).

In developing a shared decision-making observation scale for use within a psychotherapy context, the present study holds dual aims. First, to examine how feasible an observation scale is for investigating shared decision-making in psychotherapy. Second, to explore if shared decision-making can be used to build multi-level models for psychotherapy outcome indicators.

Method

Design considerations

An observation scale of shared decision-making was created to gauge whether psychotherapy decisions were shared, client-led, or therapist-led. This scale was used to rate clients' statements from their Interpersonal Process Recall interviews (Chapter, 4). These interviews contained discussions regarding audio recordings of decision-making from clients' assessment sessions.

The present study then used multi-level modelling techniques to examine any association between shared decision-making and psychotherapy outcomes. Shared decision-making coding ratings were examined alongside clinical outcomes for anxiety and depression, as well as the psychotherapy specific outcomes of client goal attainment, session effectiveness, and satisfaction. This chapter also examined satisfaction and session effectiveness from both clients' and therapists' perspective as shared decision-making requires participation from both parties (Charles, 1997). Examining these variables can expand on indications from mental health contexts of a positive impact on satisfaction outcomes (Duncan et al., 2010; Samalin et al., 2018) and on clinical outcomes for mood disorders (Samalin et al., 2018).

Participants and setting

The client sample included 14 adults taking part in pluralistic therapy for depression. All clients attended a minimum of four sessions. Clients completed on

average, over half of maximum number of available treatment sessions within the pluralistic therapy for depression ($M = 14.4/24$, $N = 14$). Half of clients attended 20 or more sessions. Further details about the client sample can be seen in chapter two, including means and ranges for all demographic variables in the present analysis.

Measures

Clinical outcome measures.

Patient health questionnaire, 9-item version (PHQ-9).

Clients completed PHQ-9 scales to measure severity of depression symptoms (Kroenke & Spitzer, 2002) (See Appendix B2). No additional permission was required for use of the PHQ-9 as the measure is publicly available (Pfizer Inc., <http://www.phqscreeners.com/select-screener>).

The nine PHQ items are drawn from the depression scale of the Patient Health Questionnaire (Spitzer, Kroenke, Williams, 1999). Together, these items can indicate the severity of depression symptoms experienced by the completing individual. The PHQ-9 can also be used by practitioners to make tentative depressive disorder diagnoses.

Clients were instructed to respond based on how often they have experienced difficulties described in the PHQ-9 items. For example, one item addresses pleasurable activities with the statement ‘little interest or pleasure in doing things’. Another item addresses suicidal thoughts or tendencies to harm the self: ‘thoughts that you would be better off dead or of hurting yourself in some way’. Clients respond to these statements on a positively scored scale from ‘not at all’ (0), to ‘several days’ (1), ‘more than half the days’ (2), and ‘nearly every day’ (3). Major depression is indicated if at least five items have a score greater than ‘more than half

the days' (2). A ninth item also measures suicidal thoughts or tendencies to harm the self.

The PHQ-9 has shown acceptable test-retest reliability and good internal consistency in a sample of 347 psychosocial support group patients (intraclass correlation = .59; Cronbach's α = .78) (Monahan et al., 2008). Monahan et al. also reported evidence for a single factor within the PHQ-9, with item loadings above .5. Arrieta et al. (2017) later demonstrated a single factor structure using confirmatory factor analysis, as well as excellent internal consistency across sub samples (Cronbach's α > .8).

The PHQ-9 has shown good convergent and predictive validity through positive associations with general health perception in a psychosocial support group sample (Monahan et al., 2008), as well as with the brief Beck's Depression Inventory and the 12-item General Health Questionnaire in a representative German sample (Martin, Rief, Klaiberg, & Braehler, 2006). Arrieta et al. (2017) later showed indications of depression severity to be associated with lower scores on an abbreviated 26-item quality of life measure (Arrieta et al., 2017).

Generalized anxiety disorder, 7-item version (GAD-7).

Clients completed GAD-7 scales to measure the severity of generalised anxiety disorder symptoms (Spitzer, Kroenke, Williams, & Lowe, 2006) (see Appendix B3). The GAD-7 can also indicate panic disorder, post-traumatic stress disorder, or social anxiety disorder. No additional permission was sought to use the GAD-7 as it is publicly available (Pfizer Inc., <http://www.phqscreeners.com/select-screener>)

The GAD-7 items ask clients how much in the last two weeks they have been bothered by feelings of worry, nervousness, restlessness, and irritability. For

example, one item asks clients how much they have been bothered by ‘feeling nervous, anxious or on edge’. Another item focuses on worry and expectations: ‘feeling afraid as if something awful might happen’. As with the PHQ-9, these items are rated on a positively scored scale from ‘not at all’ (0), to ‘several days’ (1), ‘more than half the days’ (2), and ‘nearly every day’ (3). Totalling the seven items yields a score that could indicate mild anxiety (5), moderate anxiety (10), or severe anxiety (15).

Spitzer et al. (2006) showed the GAD-7 was strongly related to the PHQ-9, although represented a distinct dimension from the PHQ-9 during factor analysis. They reported good convergent validity through strong associations with domains of functional impairment. They also show good criterion and construct validity through comparisons to mental health professionals’ diagnoses. Spitzer et al. (2006) showed the GAD-7 to hold excellent internal consistency (Cronbach’s $\alpha = .92$) and good test-retest reliability (intraclass correlation = .83). Lowe et al. (2008) showed similar findings, demonstrating excellent internal consistency in a representative German sample (Cronbach’s $\alpha = .89$). Beard and Björgvinsson (2014) later supported these good psychometric properties, showing the GAD-7 to have excellent internal consistency in a psychiatric sample (Cronbach’s $\alpha > .81$). They also reported strong associations with measures of worry, and moderate associations with measures of depression and psychological well-being.

Psychotherapy specific outcome measures.

Session effectiveness scale, client and therapist forms (SES-C; SES-T).

Therapists and clients completed Session Effectiveness Scales to measure their satisfaction with treatment sessions and their perceived effectiveness of those sessions (Elliott, 2000). Therapists and clients completed different versions of the

Session Effectiveness Scale (see Appendices B4 and B5). The scale's author gave permission for use.

The Session Effectiveness Scales include four items with differing scales to be completed at the end of treatment sessions. The first item asks respondents to rate how helpful or hindering the session was from a scale of 'extremely hindering' (1) to 'extremely helpful' (9), with a midpoint answer of 'neither helpful nor hindering; neutral' (5). The second item asks respondents to rate how they feel about the session from a scale of 'perfect' (1) to 'very poor' (7) with no neutral option. The third item asks respondents how much progress was made in dealing with the client's problems on a scale from 'a great deal of progress' (1) to 'didn't get anywhere in this session' (6), with a seventh option available of 'in some ways my problems have gotten worse this session'. A final item asks respondents if they saw the client's perspective change during the session on a reversed scale from 'not at all' (1) to 'very much' (7).

Cooper et al. (2015) demonstrated that the SES items contained acceptable internal consistency in a pluralistic therapy context (Cronbach's $\alpha = .76$). However, the Cooper et al. (2015) study calculated standardised mean scores of helpfulness across items. Whereas, the present study used item totals of helpfulness across the scale, reversing item scores where needed.

Goals Form.

Clients completed the Goals Form as an indicator of goal progress and attainment (Cooper, 2015) (see Appendix B1). The Goals Form has been used as an outcome measure in pluralistic therapy contexts (Cooper, 2014; Cooper et al., 2015). The Goals Form author granted permission for use.

The Goals Form can help structure clients' needs into workable therapy goals, with space for up to five goal items. Once constructed, the goal items are measured on a scale of progress from 'not all achieved' (1) to 'completely achieved' (7). The personalised Goals Form is then present at the start of each therapy session and can be used to form initial discussions. A mean goal score was calculated for each of the sessions at each measurement occasion.

Internal consistencies

Clients' first set of scores for each outcome measure were examined for internal consistency. All outcome measures yielded a Cronbach's alpha value over 0.8 and are therefore within the range for good internal consistency (Kline, 1986). For goals, there was no meaningful justification for examining internal consistency as each client would be creating bespoke goals with their therapist. Moreover, these clients would be arriving into therapy at different stages of progression towards those goals.

Shared decision-making observation scale.

This investigation measured the extent that clients felt their treatment decisions were shared, shared but led more by a single party, or led by a single party without being shared. To do so, an observation scale was applied to clients' transcribed statements from their IPR interview (Chapter 4). These statements were in response to audio recordings of clients' decision-making with their therapist during assessment sessions.

Clients' reports were eligible for coding in three instances. First, if those reports were in response to the researcher's questions about decision-making leadership. Second, if clients produced observations of audio recordings without being prompted by the researcher. Last, if clients' reports focused on a specific

assessment decision, rather than a general appraisal of all decisions within their assessment session.

The development of this scale drew on the previous literature and investigations within the present thesis. For example, the scale accommodated for the notion that shared decision-making can be led more by either client or therapist, whilst remaining shared. (Chapter, 3; Chapter 4; Chapter 5; Cooper & McLeod, 2011; Slade, 2017). As such, assigning a rating to a client's response depended on core criteria for shared decision-making. Ratings could be assigned based on who led or held the most influence over the decision-making process and final decision. For example, a practitioner in more paternalistic decision-making takes a leading role to make recommendations based on their professional knowledge, with a patient offering consent (Emanuel & Emanuel, 1992; Veatch, 1975). Similarly, Chapters 3 and 5 demonstrate that practitioners can lead decision negotiations with minimal influence from clients. To illustrate, a coding category of 'non-shared, therapist led' was indicated if that client reported their therapist as taking a leading role and that they had little influence beyond providing consent.

Ratings were also determined by how active therapists and clients were within decision discussions. This included the amount and types of information both parties contributed to the decision-making. For example, conceptualisations of shared decision-making propose a collaborative information exchange is required (Charles et al., 1997; Kenny, 2012, Osei-Bonsu et al., 2016). This information exchange should consist of options, clinical evidence, and a patient's preferences (Elwyn et al., 2010; Coulter & Collins, 2011). Moreover, clients in chapter four reported that both parties providing this information was helpful for facilitating shared decision-making. Other analyses have shown that such exchanges enable both

parties to co-construct relevancies for goal decisions (Chapter 5). As such, a coding category of ‘shared’ was indicated if clients reported that both parties contributed expert knowledge to decision discussions.

Clients’ statements of their assessment session decision-making were rated on a scale of: non-shared, client-led (-2); shared, but more client-led (-1); shared (0); shared, but more therapist-led (1); and non-shared, therapist-led (2). Ratings were assigned if a statement met more criteria from a single category in comparison to all other categories within Figure 7. For example, a statement rated as ‘non-shared, client led’ contained evidence of an observation or evaluation that the client was the decision-making leader and that the therapist adopted a passive role in the decision discussion without providing suggestions. For such a statement to be considered ‘shared, but more client-led’ there would need to be evidence that the therapist did contribute to the decision discussion. There would also need to be an evaluation from the client that both parties were involved or that the final decision included an earlier contribution from their therapist.

The psychometric properties of the shared decision-making coding scale will be evaluated in the present sample.

Figure 7

Shared decision-making observation scale coding criteria

Coding category	Criteria
Non-shared, client led (-2)	An explicit evaluation such as: “It was definitely me”
	An observation that the final decision was made by the client
	A report of the therapist’s role within the decision discussion as passive, such as only providing minimal agreement
	An observation of the therapist not providing their input, but encouraging the client to make a decision

Shared, but more client-led (-1)	<p>An evaluation that both parties contributed to the decision-making process, such as: “At the beginning it was probably led by [Therapist]... By the end I think it was definitely more me, led by me”</p> <p>An observation that the decision was made by both client and therapist, but more the client</p> <p>A report of the therapist as active within the decision-making process. This could include producing opinions or suggestions within the decision discussion. For example, “But based on reflecting on what [Therapist] said in the first clip”</p> <p>A report of the decision or suggestions coming from the client, but inclusive of the therapist’s previous suggestions</p>
Shared (0)	<p>An explicit evaluation such as: “It was definitely shared”</p> <p>An observation that the final decision was made by both client and therapist together</p> <p>An observation that there was equal influence in the decision-making process</p> <p>A report of the client and therapist contributing to the decision-making process, or asking each other to contribute</p>
Shared, but more therapist-led (1)	<p>An evaluation that both parties contributed to the decision-making process, such as: “It was more [therapist] in this one, but again almost a shared thing”</p> <p>An observation that the decision was made by both client and therapist, but more the therapist</p> <p>A report of the client as active within the decision-making process. This can include producing opinions or suggestions within the decision discussion</p> <p>A report of the client being asked to contribute to the decision and subsequently doing so</p> <p>A report of the decision or suggestions coming from the therapist, but inclusive of the client’s previous suggestions</p> <p>A description of the therapist guiding the client towards a decision without deciding for them. For example: “[Therapist] wasn’t saying like ‘yeah it’s avoidance’, [Therapist] kind of questioning like ‘you could say’, and I was like ‘yeah definitely’”</p>
Non-shared, therapist-led (2)	<p>An explicit evaluation such as: “It was definitely [Therapist]”</p> <p>An observation that the final decision was made by the therapist</p> <p>An explanation of the decision-making process as therapist-led. For example: “It was like [therapist] decided out of what I said what [therapist] would right down”.</p> <p>Confirmation that the client was not involved in the decision</p>

Procedure

Data was collected on three occasions: clients first treatment session, a therapy review point at session four, and clients' final treatment session. Clients completed PHQ-9, GAD-7, and Goals Forms at the start of assessment sessions and subsequent treatment sessions. Clients who did not create therapy goals did not complete the Goals Form at the start of each session. Session Effectiveness Scales were completed by therapists and clients at the end of each treatment session, but not assessment. Clients and therapists completed all measures on a handheld tablet device.

Data Analysis

Descriptive statistics and correlations were examined for all continuous variables using SPSS 24.0. Following this preliminary exploration, the analyses held two foci: to examine how feasible the shared decision-making observation scale was, and to build models for all outcome variables using shared decision-making and demographic variables. This aim was met if the scale showed appropriate internal consistency between ratings of coded statements. This could be demonstrated by a Cronbach's alpha between .6 and .99 (Kline, 1986). Moreover, ratings should show good inter-rater agreement through a correlation across multiple raters between .61 and .99 (Landis & Koch, 1977).

Multi-level modelling techniques were used to pursue the second aim. Multi-level analysis techniques are often used to examine large data sets to make predictions for outcome variables. These techniques assume that human and scientific data can have clustered, hierarchical, or nested structures (Rasbash, 2008). Rasbash states that multi-level modelling can be used to explore how relationships vary across higher-level groupings. For example, examining relationships between

clients' data grouped by therapist, rather than grouped by individual client only.

However, such techniques can also be used for longitudinal data when a correlation is expected between individual participants' responses over time (Rasbash, 2008).

For example, the present analysis assumes a client's PHQ-9 scores will be correlated over the course of their treatment.

Research examining psychotherapy outcomes and processes have used multi-level modelling methods in their investigations. Tasca and Gallop (2009) proposed that such methods can be useful for examining change and development in clients throughout treatment. For example, Cooper (2012) examined 86 therapy dyads' changes in perceptions of relational connectedness and what the predictors of those perceptions were. Cooper built models of therapists' and clients' perceptions using the time point of measurement as the first level and the therapy dyad as the second level. They showed that perceptions of connectedness for both therapist and client models increased over time, but that the rate of increase reduced over time. Later, Green, Barkham, Kellet, and Saxon (2014) applied multi-level modelling to examine therapist effects on anxiety and depression outcomes. Green et al. built separate anxiety and depression models with clients as the first level, and practitioner as the second level. When controlling for pre-treatment scores, therapist effects could account for approximately 9% of variability in client anxiety and depression scores. Together, these studies demonstrate the appropriateness of multi-level methods for examining psychotherapy outcomes and processes across therapists, clients, and time.

Two-classification, repeated measures, longitudinal analyses were performed using MLWIN 3.01. The term *classification* is often used interchangeably with *levels*, although the term *level* implies a nested hierarchical relationship of units

(Rasbash, 2008). Such hierarchical relationships are not present in the current data set. Models were developed using measurement timepoint as the first classification, and client as the second. These models examined PHQ-9, GAD-7, SES-C, SES-T, and Goals Form scores and any interactions they had with demographic variables and shared decision-making coding ratings.

Each model was developed using the Hox methodology (Hox, 2010; Hox & Maas 2005). To do so, an intercept-only model was created for each outcome variable. If varying that intercept by client yielded a significant difference in log likelihood scores, demographic and shared decision-making variable terms were independently tested within those models.

Variable terms were eligible to be accepted into a model if they met two criteria. First, if the term yielded a beta coefficient that significantly differed from its standard error. This was calculated by dividing each term's beta coefficient by their standard error and performing a *t*-test with one degree of freedom. Given the small sample size and exploratory nature of this analysis, the present analysis did not account for multiple testing and treated variable terms as significant at an unadjusted value of *p* less than .05. Moreover, any *p* values between .05 and .2 were reported as a trend and eligible for inclusion in the models.

Second, terms were eligible to be accepted into the model if they could improve the fit of models to the data. This was assessed by performing chi-squared test for the difference between log likelihood ratio statistics before and after a variable term was added. A variable term was eligible to be accepted into a model if the chi-squared test produced a *p* value less than .05. However, terms would be considered for acceptance if they showed a trend at a *p* value less than .2. Variable terms were not eligible to be accepted into a model if the *t*-test between its beta

coefficient and standard error yielded a p value above .2, but the chi-squared test of log likelihood differences did not. As such, when deciding to accept a variable term into a model, a chi-squared indicating improved model fit was given priority over a beta coefficient differing from its error. After each variable term was tested in a model, the interaction between that term and the number of sessions beyond assessment was tested. Following the addition of a variable term to the model, all remaining variable terms were tested again.

During model development, priority was given to testing demographic variables before any shared decision-making variable terms were tested. This order was intended to control for any impact the demographic variables may have had on the outcome variables.

Variables.

All data was transformed from a wide form data sheet organised by client, to a long form data sheet organised first by measurement occasion, then client. The data set was determined to not have any minor or major outliers. To do so, inner and outer fences were calculated for each variable using inter-quartile ranges. No values were outside of these fences. Variance, skewness, Q-Q plots, and histograms were examined for each continuous variable and showed that no variables deviated from a normal distribution.

Outcome variables.

All outcome variables included in analysis corresponded to the three measurement occasions of: a client's first treatment session, a session four therapy review, and their final treatment session. There was a reduction in available data for participants from the first to the last session, yet this difference was not significant. Descriptive statistics for all outcome variables can be seen in table 6.

PHQ-9 scores on average, decreased over time. The PHQ-9 mean decreased from session one ($M = 17.9, n = 13$) to session four ($M = 15.4, N = 14$), and again by clients' final sessions ($M = 14.3, N = 14$). A similar pattern was seen within GAD-7 scores, with the mean reducing from session one ($M = 12.4, N = 14$) to session four ($M = 10.9, N = 14$), and again by clients' final sessions ($M = 9.7, N = 14$). Together, the decreases in PHQ-9 and GAD-7 mean scores suggest that clients on average, improved over the course of treatment.

The SES-C mean at clients' first treatment sessions was 20.8 ($n = 11$). This mean increased by clients' therapy review sessions ($M = 22.5, N = 14$) and remained higher by clients' final sessions ($M = 21.5, N = 14$). The mean SES-T score for clients' first treatment sessions was 16.3 ($n = 8$). This mean reduced by clients' therapy review sessions ($M = 16, n = 10$), but increased by their final sessions ($M = 17.3, n = 10$). The SES means across the three measurement occasions indicate that clients rated their sessions on average, as more effective than their therapists did.

Goals Form mean scores increased from session one ($M = 2.6, n = 12$) to therapy review points at session four ($M = 3.5, n = 11$), and again by clients' final therapy sessions ($M = 3.9, n = 8$). These means indicate that clients on average, felt they made progress towards attaining their therapy goals between their first and final sessions.

Table 6

Means and standard deviations for outcome and shared decision-making variables

	<i>N</i>	<i>M</i>	<i>SD</i>
PHQ-9			
Session one	13	17.9	5.9
Session four	14	15.4	7.5
Final session	14	14.3	8
GAD-7			
Session one	14	12.4	5
Session four	14	10.9	5.5
Final session	14	9.7	5.9
SES-C			
Session one	11	20.8	3.1
Session four	14	22.5	1.3
Final session	14	21.5	6.6
SES-T			
Session one	8	16.3	1.5
Session four	10	16	4.3
Final session	10	17.3	4.3
Goals			
Session one	12	2.6	1.3
Session four	11	3.5	1.5
Final session	8	3.9	1.9

Note. PHQ-9 = Patient Health questionnaire 9; GAD-7 = Generalized Anxiety Disorder 9; SES-C = Session Effectiveness Scale (client version); SES-T = Session Effectiveness Scale (therapist version).

Demographic variables.

One demographic variable, age, was tested in all models as a continuous variable. Two categorical demographic variables were tested in all models: sex, with ‘female’ coded as 2, and ‘male’ coded as 1; and whether clients were taking anti-depressant medication at assessment, with ‘yes’ coded as 2 and ‘no’ coded as 1.

Shared decision-making.

Two shared decision-making variables were included in the present analysis, raw and transformed averages. For *shared decision-making raw averages*, means of each client's coding ratings to provide a single value between -2 and 2.

Shared decision-making transformed averages were derived to provide a score on a single, positive scale. To do so, clients' raw average scores were reversed on a subscale of either shared to therapist-led (0 to 2), or client-led to shared (-2 to 0). This resulted a single scoring indicator representing both 'therapist-led' and 'client-led' at a mid-point (0), and shared at both poles (-2, 2). Each reversed average was then squared to ensure all integers were positive, then square rooted to return them to their original state. This provided a score for each client on a positive scale from decisions that were not shared and categorised as 'client-led' or 'therapist-led' (0), to 'shared' (2).

Missing data.

The PHQ-9 had a single missing value from one client's first treatment session. No values were missing from the GAD-7 data. The Goals Form had 11 missing values across seven clients and all three measurement points. However, six of the missing Goals Form values were from two clients who decided not use goals in their treatment. Client SES scores were missing three values from three clients' first treatment sessions. Fifteen values were missing from therapist SES scores across 10 clients and all three measurement occasions. One client was missing all three therapist SES scores. No data was missing from the demographic or shared decision-making variables. Yet, multi-level analysis does not require balanced data or for participants to have the maximum number of observations (Leckie, Morris, & Steele, 2016). This enables researchers to retain participants with missing data without further adjustment.

Results

Shared decision-making observation scale psychometric properties

Descriptive statistics.

The shared decision-making observation scale was used to rate 58 extracts across 14 clients. An average of four extracts were coded per client ($M = 4.13$, $N = 14$). Three and five extracts were coded for four clients each, and four extracts were coded for three clients. One, six, and seven extracts were coded for a single client each. Clients felt that their therapy decisions at assessment were on average, closer to being shared than being client-led or therapist-led ($M = 0.3$, $N = 14$). This mean was also closer to being shared but therapist-led, than to shared but client-led. Coding ratings ranged from decisions that were closer to client-led (-1.3) to those that were closer to therapist-led (1.8).

Inter-rater reliability.

The researcher and a co-researcher applied the shared decision-making observation scale to nine extracts from clients' transcripts. This was 5% of the total coded extracts. Both sets of ratings had means (0.22, $n = 9$) and medians (0, $n = 9$) that were closer to 'shared' (0) than 'client-led' (-2) or 'therapist-led' (2). Cohen's Kappa was used to examine inter-rater reliability of coding categories, as proposed for two coders of nominal data (Hallgren, 2012). There was substantial agreement between the two raters (Cohen's $k = .72$, 95% CI [0.39-1.05], $p < .001$) (Landis & Koch, 1977). Coding ratings from both researchers can be seen in appendix F.

Internal consistency.

Shared decision-making coding ratings were examined for internal consistency. The number of extracts rated per interview transcript ranged from one to seven. Ratings for the first three, four, and five coded extracts per client yielded

Cronbach's alphas of .66, .75, and .62 ($N = 14$), respectively. Therefore, the ratings demonstrated acceptable internal consistency between ratings of clients' coded statements.

Outcome and process variable correlations

Two-tailed, bivariate Pearson correlations were performed between all outcome and process variables. Change scores for the PHQ-9 and GAD-7 were also examined. These change scores consisted of the differences between a client's PHQ-9 and GAD-7 scores at assessment and in their final session. The correlations examined relationships across the three measurement occasions and showed 23 significant interactions out of the 132 examined. The correlation matrix for all outcome and process variables can be seen in table 7.

Two outcome variables showed trends towards positive associations with *shared decision-making transformed averages*. First, therapists' final SES-T ratings showed a trend towards a positive relationship with *shared decision-making transformed averages* ($r = .48, p = .16, n = 10$). Second, clients' final ratings of their goal progress showed a positive trend towards a relationship with *shared decision-making transformed averages* ($r = .65, p = .08, n = 8$).

Table 7

Pearson's correlations for all outcome and process variables

	PHQ-9				GAD-7				SES-C			SES-T			Goals		
	Session one	Session four	Final session	Change score	Session one	Session four	Final session	Change scores	Session one	Session four	Final session	Session one	Session four	Final session	Session one	Session four	Final session
GAD-7																	
Session one	.64*	.58*	.6*	.31													
Session four	.8**	.85**	.6*	.31													
Final session	.73**	.79**	.88**	.67**													
Change score	.28	.43	.65*	.56*													
SES-C																	
Session one	-.41	-.29	-.03	.37	.2	-.3	.21	.08									
Session four	-.65*	-.57*	-.5	-.07	-.18	-.44	-.41	-.4									
Final session	-.33	-.3	-.53	-.39	-.02	-.03	-.17	-.42									
SES-T																	
Session one	.16	.14	-.23	.13	-.08	.38	.15	-.04	-.43	.03	.23						
Session four	.44	.27	.2	-.09	.51	.43	.08	-.36	-.19	.13	-.42						
Final session	.28	.29	.13	-.15	.36	.39	.34	.1	.42	.05	.6						
Goals																	
Session one	-.69*	-.54	-.75**	-.37	-.49	-.36	-.72**	-.5	.2	.42	.4	-.34	.16	-.07			
Session four	-.72*	-.67*	-.77**	-.25	-.44	-.47	-.77**	-.71*	.03	.61*	.12	-.13	.02	-.69			
Final session	-.68	-.42	-.69	-.43	-.44	-.33	-.77*	-.79*	.31	.6	.54	.39	.01	.01			
SDM raw	-.08	-.01	.14	.08	-.04	.11	.14	-.16	-.17	-.03	-.09	.16	-.1	-.18	-.12	-.1	-.36
SDM trans	.07	.27	-.1	.08	.05	.3	0	-.16	.08	.21	.18	.28	.23	.48	.36	.17	.65

Note. PHQ-9 = Patient Health questionnaire 9; GAD-7 = Generalized Anxiety Disorder 9; SES-C = Session Effectiveness Scale (client version); SES-T = Session Effectiveness Scale (therapist version); SDM raw = Shared decision-making raw averages; SDM trans = shared decision-making transformed averages; * correlation significant at $p < .05$; ** correlation significant at $p < .001$.

Multi-level models

PHQ-9.

Model summary.

Three variable terms could significantly improve the fit of the intercept-only PHQ-9 model. A further two terms showed a trend towards an improved fit. No beta coefficients significantly differed from their error, but four terms showed a trend. All PHQ-9 models had an equal number of cases across clients ($n = 41, 14$).

Intercept-only.

An intercept-only model of client's PHQ-9 scores showed a mean score at time zero of 16.12 and a variance of 48.99. Varying the intercept by client gave a mean at time zero of 16.22 and significantly reduced the log likelihood ratio statistic from the previous model ($-25.02, p < .001$). Doing so yielded a session level variance of 11.80 and a client level variance of 37.19, for a variance partition coefficient of .76. Together, these results suggest that PHQ-9 scores differed across clients, across treatment. Therefore, showing the appropriateness of proceeding with the PHQ-9 model development.

Testing the term for number of *sessions from assessment* improved the model fit by significantly reducing the log likelihood statistic ($-6.51, p = .01$). For *sessions from assessment* there was a trend towards PHQ-9 scores decreasing across treatment ($\beta = -0.19, p = .11$). Given this improved model fit and predictive trend, *sessions from assessment* was accepted as part of the final model. Varying *sessions by assessment* by client did not cause any changes in variance statistics, nor improve the model fit.

Demographic variables.

Three terms could significantly improve the PHQ-9 model. *Sex* and its subsequent interaction with *sessions from assessment* yielded the greatest reduction in log likelihood statistics, lowest *p* value of any predictive trend, and greatest amount of variance explained in PHQ-9 scores. Adding these terms demonstrated a trend towards males having a greater rate of reduction in severity of their depression symptoms over time ($\beta = -0.5, p = .09$). These terms significantly reduced the log likelihood statistic ($-8.85, p = .003$). As such, this interaction and the original *sex* term were accepted into the final model.

Age also yielded a significant improvement to model fit ($-4.14, p = .04$), with a trend towards younger clients being associated with reduced PHQ-9 scores ($\beta = -0.85, p = .04$). However, adding the interaction between *age* and *sessions from assessment* yielded a weaker beta coefficient and a greater *p* value in comparison to adding the interaction for *sex*. Table 8a shows all demographic variable terms tested at this stage of model development.

Table 8a

Demographic terms tested in the PHQ-9 model following sessions from assessment

	Centring or Reference category	β (error)	P	Variance partition coefficient	Log likelihood change	p
Age	0	-0.85 (0.38)	.14	.73	-4.14	.04
Sex*	Female	-0.40 (3.84)	.47	.80	-0.02	.75
Anti-depressant medication	No	1.00 (3.5)	.41	.81	-0.08	.78
Interaction with time						
Age	0	0.01 (0.02)	.41	.73	-4.22	.04
Sex*	Female	-0.50 (0.15)	.09	.85	-8.85	.003
Anti-depressant medication	No	-0.24 (0.15)	.18	.82	-2.67	.10

Note. * = retained variable term.

Shared decision-making.

The interaction between *shared decision-making transformed averages* and *sessions from assessment* was accepted into the final model as it showed a trend towards improved model fit and being able to predict PHQ-9 scores. This interaction reduced the log likelihood statistic (-2.00, $p = .16$) and yielded a trend towards more shared decisions predicting PHQ-9 decreases across treatment ($\beta = -0.14$, $p = .20$). As such, the original *shared decision-making transformed averages* term was also added to the final model. Shared decision-making variables terms tested in the model can be seen in table 8b.

Table 8b

Shared decision-making terms tested in the PHQ-9 model

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
SDM raw averages	GM	0.23(1.86)	.46	.86	-0.01	.92
SDM transformed averages*	GM	1.64 (3.65)	.37	.85	-0.20	.65
Interaction with time						
SDM raw averages	GM	0.08 (0.07)	.23	.85	-1.32	.25
SDM transformed averages*	GM	-0.14 (0.1)	.20	.86	-2.00	.16

*Note: SDM = shared decision-making; GM = grand mean; * = retained variable term.*

Final PHQ-9 model.

The final PHQ-9 model contained, in order: the intercept varied by client; *sessions from assessment*; *sex*; *sex* and its interaction with *sessions from assessment*; *shared decision-making transformed averages*; and this shared decision-making term's interaction with *sessions from assessment* (see Table 8c). This model had a session level variance of 6.40 and a client level variance of 38.10. Together, the added terms were able to explain 86% of the variance in PHQ-9 scores at client level.

Table 8c

Variable terms accepted into the PHQ-9 model

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
Intercept varied by client				.76		
Sessions from assessment	0	-0.19 (0.07)	.11	.81	-6.51	.01

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
Sex	Female	-0.40 (3.84)	.47	.80	-0.02	.75
Sex and interaction with time	Female	-0.50 (0.15)	.09	.85	-8.85	.003
SDM transformed averages	GM	1.64 (3.65)	.37	.85	-0.20	.65
SDM transformed averages and interaction with time	GM	-0.14 (0.1)	.20	.86	-2.00	.16

Note: SDM = shared decision-making; GM = grand mean.

GAD-7.

Model summary.

Two terms showed a trend towards improved model fit. All GAD-7 models contained the same number of cases across clients ($n = 42, 14$).

Intercept-only.

The intercept-only model of client's GAD-7 scores had a variance of 29.24, with a mean score at time zero of 11. Varying the intercept by client did not alter the mean, but yielded a session level variance of 10.33, a between participant variance of 18.91, and a variance partition coefficient of .65. Doing so also significantly reduced the log likelihood statistic ($-17.5, p < .001$). Therefore, indicating that GAD-7 scores differed across clients, across treatment.

As with the PHQ-9 model, *sessions from assessment* were added to the final GAD-7 model. Adding the *sessions from assessment* term yielded a significantly reduced log likelihood from the intercept-only model ($-4.51, p = .03$), and showed a trend for client reductions in anxiety symptoms across treatment ($\beta = -0.15, p = .14$).

Therefore, suggesting that clients could have differed on their rate of reduction in their depression symptoms.

Demographic variables.

The interaction between *sex* and *sessions from assessment* was accepted into the final model as it yielded a trend towards an improved model fit. Therefore, original *sex* term was also included in the final model. Adding these terms reduced log likelihood statistic (-1.94, $p = .16$), but did not show a predictive trend. All demographic variable terms tested at this stage can be seen in table 9a.

Table 9a

Demographic terms tested in the GAD-7 means model following sessions from assessment

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
Age	0	-0.07 (0.15)	.43	.67	0.02	.89
Sex*	Female	-0.59 (0.15)	.43	.67	-0.06	.81
Anti-depressant medication	No	-0.76 (0.15)	.41	.68	-0.11	.74
Interaction with time						
Age	0	-0.02 (0.15)	.24	.67	-1.14	.29
Sex*	Female	-0.23 (0.15)	.21	.69	-1.94	.16
Anti-depressant medication	No	-0.04 (0.15)	.43	.68	-0.17	.68

Note. * = retained variable term.

Shared decision-making.

Shared decision-making transformed averages and its interaction with *sessions from assessment* was accepted into the final model. Adding this term indicated the greatest improvement to model fit through reduction of the log likelihood statistic (-2.23, $p = .14$). The original *shared decision-making transformed averages* was therefore also included in the final model. All shared decision-making variables tested at both model development stages can be seen in table 9b.

Table 9b

Shared decision-making terms tested in the GAD-7 model

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
SDM raw averages	GM	0.35 (1.37)	.42	.69	-0.06	.61
SDM transformed averages*	GM	1.64 (2.71)	.33	.69	-0.38	.54
Interaction with time						
SDM raw averages	GM	0.08 (0.08)	.25	.68	-0.99	.32
SDM transformed averages*	GM	-0.16 (0.12)	.21	.69	-2.23	.14

Note: SDM = shared decision-making; GM = grand mean; * = retained variable term.

Final GAD-7 model.

The final model GAD-7 contained, in order: the intercept varied by client, *sessions from assessment*, *sex*, the interaction between *sex* and *sessions from assessment*; *shared decision-making transformed averages*, and the interaction between those transformed averages and *sessions from assessment* (see Table 9c). The final model showed a session level variance of 8.51, a client level variance of 18.98, and a variance partition coefficient of .69. Therefore, suggesting that 69% of the variance at the client level could be explained by the added terms.

Table 9c

Variable terms accepted into the GAD-7 model

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
Intercept varied by client				.65		
Sessions from assessment	0	-0.15 (0.07)	.14	.67	-4.51	.03
Sex	Female	-0.59 (0.15)	.43	.67	-0.06	.81
Sex and interaction with time	Female	-0.23 (0.15)	.21	.69	-1.94	.16
SDM transformed averages	GM	1.64 (2.71)	.33	.69	-0.38	.54
SDM transformed averages and interaction with time	GM	-0.16 (0.12)	.21	.69	-2.23	.14

Note: SDM = shared decision-making; GM = grand mean.

SES-C.

Model summary.

Two terms could significantly improve the intercept-only SES-C model, with another showing a trend towards improved fit. One term showed a trend towards its beta coefficient significantly differing from its error. All tested SES-C models contained equal cases across clients ($n = 39, 14$). There was no meaningful justification for examining the rate of change for session effectiveness scores. This is due to research in psychotherapy showing no conclusive evidence for longer-term therapy being more effective than shorter term treatment (Bhar et al., 2010).

Therefore, the *sessions from assessment* interactions were not tested in any of the SES-C models.

Intercept-only.

An intercept-only model for SES-C scores showed a mean at time zero of 21.51 and a variance of 19.22. Allowing the intercept to vary by client yielded a mean of 21.60 and significantly reduced the log likelihood ratio statistic ($-3.87, p = .05$). This model showed a session level variance of 12.43, a client level variance of 6.80, and a variance partition coefficient of .35.

Demographic variables.

Two terms significantly improved the model fit from the intercept only-model, with *sex* added to the model. Yet, testing *age* in the model resulted in the greatest improvement to model fit ($-9.61, p = .002$), with the beta coefficient showing a positive predictive trend ($\beta = 3.14, p = .08$). However, *age* also resulted in a variance partition coefficient of .04 and a coefficient at later development stages of 0, indicating this term to be problematic when added to the model.

Sex was added at this stage of model development as it enhanced model fit and showed the greatest predictive trend. Adding this term showed a variance partition coefficient of .31, in comparison to the .04 coefficient from adding *age*. Adding *sex* yielded a log likelihood statistic reduction ($-2.66, p = .10$) and suggested that being male showed the strongest positive trend with SES-C scores ($\beta = 3.14, p = .17$). All demographic variables tested in the model can be seen in table 10a.

Table 10a

Demographic terms tested in the SES-C intercept-only model

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
Stage 1: intercept-only model						
Age	0	0.60 (0.16)	.08	.04	-9.61	.002
Sex*	Female	3.14 (1.88)	.17	.31	-2.66	.10
Anti-depressant medication	No	1.08 (1.81)	.33	.35	-0.35	.55

Note: * = retained variable term.

Shared decision-making.

No shared decision-making variables significantly differed from their errors or significantly reduced the log likelihood statistic from the model inclusive of *sex*. Therefore, model development did not continue for the SES-C outcome variable. The shared decision-making terms tested at these development stages can be seen in table 10b.

Table 10b

Shared decision-making terms tested in the SES-C models

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
SDM raw averages	GM	0.29 (0.86)	.40	.34	-0.12	.73
SDM transformed averages	GM	0.89 (1.68)	.35	.33	-0.29	.59

Note: *SDM* = shared decision-making; *GM* = grand mean.

SES-T.***Model summary.***

One variable term yielded a trend towards an improved fit for the SES-T model beyond the intercept-only model. The SES-T models had a reduced number of cases across clients, compared to the other outcome variables ($n = 27, 13$). As with the SES-C model, there was no meaningful justification for examining any rate of change of session effectiveness scores. Therefore, *sessions from assessment* was not tested in any of the SES-T models.

Intercept-only.

The intercept-only model showed a mean score at time zero of 16.41 and a variance of 10.32. Allowing the intercept to vary by client yielded a mean at time zero of 16.36, a session level variance of 8.67, a client level variance of 1.65, and a variance partition coefficient of .16. Doing so reduced the log likelihood statistic and indicated an improved model fit ($-0.37, p = .05$). This model indicated that SES-T scores varied across clients.

Demographic variables.

No demographic terms could be added to improve the intercept-only model, nor had any beta coefficients that significantly differed from their errors. All demographic variables tested in the intercept-only model can be seen in table 11a.

Table 11a

Demographic terms tested in the SES-T intercept-only model

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
Age	0	0.09 (0.18)	.35	.16	-0.24	.62
Sex	Female	0.52 (1.62)	.40	.15	-0.10	.75
Anti-depressant medication	No	0.29 (1.37)	.43	.15	-0.05	.82

Note: * = retained variable term.

Shared decision-making.

Shared decision-making transformed averages was accepted into the final model after showing trends towards improving model fit and positively predicting SES-T scores. Testing this term yielded a trend towards more shared decisions at assessment being associated with increased therapists' ratings of session effectiveness ($\beta = 2.18, p = .16$). Moreover, the log likelihood ratio statistic reduced from the intercept-only model ($-2.8, p = .09$). However, the variance partition coefficient was reduced to less than .001. Results from testing both shared decision-making terms and their interactions are available in table 11b.

Table 11b

Shared decision-making terms tested in the SES-T intercept-only model

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
SDM raw averages	GM	0.70 (1.75)	.38	.14	-0.19	.66
SDM transformed averages*	GM	2.18 (1.19)	.16	< .001	-2.80	.09

Note: SDM = shared decision-making; GM = grand mean; * = retained variable term.

Final SES-T model.

The final model for SES-T scores included the intercept varied by client and *shared decision-making transformed averages* (see Table 11c). The final model yielded a session level variance of 9.17, but a client level variance less than .001. This low value limited any conclusions for how much client-level variance could be explained by shared decision-making.

Table 11c

Variable terms accepted into the SES-T model

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
Intercept varied by client				.16		
SDM	GM					
transformed		2.18				
averages		(1.19)	.16	< .001	-2.80	.09

Note: SDM = shared decision-making; GM = grand mean.

Goals.

Model summary.

Five terms showed trends towards improved goals model fit. Two terms showed trends for their beta coefficients differing from their errors. All goals models had a reduced number of cases compared to the PHQ-9, GAD-7, and SES-C models ($n = 31, 12$).

Intercept-only.

The intercept-only model showed a mean at time zero of 3.38 and variance in mean goal attainment scores of 2.05. Varying the intercept by client yielded a mean at time zero of 3.49 and significantly reduced the log likelihood ratio statistic (-8.36, $p = .004$). This model showed a session level variance of 0.67 and a between participant variance of 1.38, for a variance partition coefficient of .67. Therefore, suggesting that goal means varied across clients, across treatment.

Sessions from assessment was accepted as part of the final goals model.

Testing *sessions from assessment* in the model showed a trend towards clients mean goal scores improving as treatment progressed ($\beta = 0.05, p = .11$). This term also significantly reduced the log likelihood, indicating a better model fit (-4.48, $p = .03$).

Allowing the term to vary by client caused no changes to variance nor model fit.

Therefore, suggesting that the scores varied at both client and session levels.

Demographic variables.

Three terms showed trends towards improved model fit, with *age* accepted into the final model. This was due to *age* showing the greatest log likelihood statistic reduction ($-3.41, p = .06$) and a trend towards older clients being associated with higher goal means scores ($\beta = 0.12, p = .19$). All demographic variable terms tested in the goals model can be seen in table 12a.

Table 12a

Demographic terms tested in the goal means model following sessions from assessment

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
Age*	0	0.12 (0.08)	.19	.63	-3.41	.06
Sex	Female	0.62 (0.76)	.28	.72	-1.42	.23
Anti-depressant medication	No	0.31 (0.74)	.38	.75	-0.41	.52
Interaction with time						
Age	0	0.002 (0.004)	.35	.62	-3.63	.06
Sex	Female	0.03 (0.04)	.30	.72	-1.88	.17
Anti-depressant medication	No	0.02 (0.04)	.36	.75	-0.62	.43

Note: * = retained variable term.

Shared decision-making.

The interaction between *shared decision-making raw averages* and *sessions from assessment* was accepted into the final model. This was due to the interaction yielding the strongest trend of the two shared decision-making variables towards model improvement. This is evident through the reduced log likelihood statistic ($-2.91, p = .09$) and trend towards more therapist-led decisions being associated with slower rates of mean goal progress across treatment ($\beta = -0.04, p = .18$). The original *shared decision-making raw averages* term was also retained in the final model. All shared decision-making variable terms tested in the goals model can be seen in table 12b.

Table 12b

Shared decision-making terms tested in the goal means models

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
SDM raw averages*	GM	-0.29 (0.29)	.25	.5	-0.84	.36
SDM transformed averages	GM	0.99 (0.75)	.21	.47	-1.39	.24
Interaction with time						
SDM raw averages*	GM	-0.04 (0.02)	.18	.43	-2.91	.09
SDM transformed averages	GM	0.07 (0.05)	.21	.43	-2.76	.10

*Note: SDM = shared decision-making; GM = grand mean; * = retained variable term.*

Final goals model.

The final goals model contained, in order: the intercept varied by client; *sessions from assessment*; *age*; *shared decision-making raw averages*; and the interaction between those raw averages and *sessions from assessment* (see Table 12c). This model yielded a session level variance of 0.76 and a client level variance

of 0.57. Together, the added terms explained 43% of the variance at client level. This model suggests that clients were likely to make progress towards their goals as treatment progressed. Moreover, there were trends towards older clients being associated with greater goal means, and more therapist led decisions associated with slower rates of goal progress.

Table 12c

Variable terms accepted into the Goals model

	Centring or Reference category	β (error)	p	Variance partition coefficient	Log likelihood change	p
Intercept varied by client				.67		
Sessions from assessment	0	0.05 (0.02)	.11	.76	-4.48	.03
Age	0	0.12 (0.08)	.19	.63	-3.41	.06
SDM raw averages	GM	-0.29 (0.29)	.25	.5	-0.84	.36
SDM raw averages and interaction with time	GM	-0.04 (0.02)	.18	.43	-2.91	.09

Note: SDM = shared decision-making; GM = grand mean.

Discussion

The present study had two aims. First, to examine the feasibility of measuring shared decision-making in psychotherapy with a new observation scale. This scale was used to rate clients' evaluations of their assessment decision-making on a scale from client-led to therapist-led, with 'shared' as the mid-point. The scale

showed acceptable internal consistency and good reliability between two raters. As such, the present study successfully met this first aim.

The second aim was to explore whether shared decision-making can be used to build multi-level models for psychotherapy outcome indicators. Shared decision-making ratings could add to multi-level models for four out of five psychotherapy outcome measures. These consisted of: depression severity, anxiety severity; therapist ratings of session effectiveness and satisfaction; and goal progress. Shared decision-making added to these models after controlling for time, excluding the model for therapist session effectiveness ratings. Shared decision-making added to the models for depression and anxiety after controlling for clients' sex and an interaction between sex and time. As such, the present analysis shows this second aim was successfully met.

Depression and anxiety

When controlling for time and sex, there was a trend for more shared assessment decisions to be associated with reductions in PHQ-9 scores. Time, sex, and shared decision-making could explain a majority of the variance in PHQ-9 scores at the client-level.

The PHQ-9 model provides tentative evidence to support Samalin et al.'s. (2018) systematic review. Samalin et al. reported indications of shared decision-making benefiting mood disorder treatment outcomes. Clients within their review received similar treatment to those in the present sample. However, many of Samalin et al.'s sample also received general practitioner care and management, as well as anti-depressant medication. Together, both sets of findings support the notion of shared decision-making as being potentially beneficial for clients seeking help with mood disorder symptoms.

Similarly, the GAD-7 model suggests clients' anxiety symptoms reduced over treatment, with shared assessment decisions potentially contributing to this reduction. When controlling for sex and time, there was a trend for more shared decisions at assessment being associated with greater rates of anxiety symptom reduction. Adding sex, time, and shared decision-making to the GAD-7 model could explain a majority of the variance in client's scores.

The GAD-7 model's tentative indications of anxiety treatment benefits share similarities to McKay's (2011) findings. McKay showed clients in a shared decision-making intervention had greater generalised anxiety improvement by treatment session three, compared to a control group. Yet, McKay found no difference between the intervention and control group after session six. The GAD-7 model adds to these findings, indicating a trend towards an increased rate of anxiety symptom reduction as treatment progressed. Thereby, showing the potential for an enduring relationship between shared decision-making and anxiety reduction, rather than a static or immediate relationship at the beginning of treatment only. However, it would be useful for drawing firmer conclusions to gauge the amount of continuing shared decision-making between therapy dyads. This would help determine whether any anxiety treatment benefits likely arise from initial shared decision-making at the start of treatment, an ongoing shared decision-making process, or both.

The PHQ-9 and GAD-7 models offer support for shared decision-making being associated with a lack of harm to clients. These models build on Duncan et al.'s. (2010) findings from their review of shared decision-making interventions in mental health. Duncan and colleagues found no indications of harm to patients from taking part in shared decision-making. Similarly, the PHQ-9 and GAD-7 models demonstrated positive clinical outcomes during a shared decision-making

emphasising treatment. Thus, the models show that positive clinical outcomes can occur in the presence of shared decision-making. This indicates that shared decision-making may not hinder the pursuit of positive clinical outcomes in psychotherapies.

Session effectiveness and satisfaction

The model for client-rated session effectiveness and satisfaction was limited by being unable to add shared decision-making terms to the final model. This contrasts with the findings from mental health and healthcare. For example, shared decision-making is associated with increases in patients' satisfaction with both the decision-making process and the final decision (Loh et al., 2007; Aljumah et al., 2015; Ishii et al., 2017). Therefore, the psychotherapy field would benefit from further investigations exploring any interactions between client perceived satisfaction and how much shared decision-making occurred throughout treatment.

The final model for therapist-rated session effectiveness and satisfaction showed a trend towards higher ratings being associated with more shared assessment decisions. The present correlational evidence also showed a trend towards a positive association between therapists' last ratings of session effectiveness and the amount assessment decisions were shared. However, the final model limited any conclusions that could be drawn regarding how much variance shared decision-making could explain in therapist session effectiveness scores at the client level.

The model for therapist session effectiveness ratings shares similarities with psychotherapy and mental health research findings. For example, Hamann et al. (2006) and Leblanc et al. (2015) showed that practitioners taking part in shared decision-making interventions were more satisfied with the decision-making process, compared to practitioners from a control condition. The shared decision-making practitioners were also more satisfied with the final decisions. The present analysis

also offers tentative support for practitioners' views reported by Chong et al. (2013), Castillo-Tandazo et al. (2016), and Paraskeva et al. (2016). These studies showed practitioners thought favourably of both the concept and their use of shared decision making. Together, the present findings and those from research in mental health indicates that practitioners could be more satisfied with shared treatment decisions, rather than those led by the therapist or client only. This increased satisfaction could be due to shared decision-making being a process that recognises both practitioner and client knowledge in creating treatment decisions (Charles et al., 1997; 1999; Coulter & Collins, 2011). Moreover, such decisions would arise from discussions between both parties to ensure that the decisions fits both the practitioners' professional opinion and the patient's needs and preferences.

Goals

The goals model tentatively suggests clients were likely to make progress towards their goals over treatment. After controlling for age, there was a trend towards more therapist-led assessment decisions being associated with slower goal progress. Together, these terms could explain 43% of the variance at the client level. The correlational evidence also showed a trend towards more shared decisions at assessment being associated with greater goal progress at clients' final treatment sessions.

The goals model suggests that clients might make slower goal progress throughout treatment when experiencing more therapist-led assessment decisions, inclusive of goals. However, decision-making rated as more therapist-led by the shared decision-making observation scale could still be shared. This model supports Paraskeva et al.'s (2016) findings for a pre-treatment shared decision-making intervention. Paraskeva et al. reported increased patient comfort and feelings of

usefulness for goals created through shared decision-making. Together, the goals model and Paraskeva et al.'s findings imply that clients perceive shared goal decisions more favourably than those that are more therapist-led. As such, it would be useful to understand if more shared goal decisions are optimal for goal progress, compared to entirely therapist-led or client-led decisions.

The goals model and research findings from psychotherapy contexts indicate that using patient preferences in goal designs may be beneficial to goal attainment. This is due to the trend towards less shared decisions at assessment being associated with slower rates of goal progress across treatment. These assessment decisions would have likely included goal decisions, as per the pluralistic protocol (McLeod & Cooper, 2012). As such, the goals model can support the findings from mental health and psychotherapy research. For example, that accommodating for a client's preferences is associated with favourable mental health and psychotherapy outcomes, as well as treatment adherence (Kwan et al, 2010; Lin et al., 2005; Linhiem et al., 2014; Swift & Callahan, 2009; Swift & Callahan, 2010; Williams et al., 2016). However, further evidence would be useful to support these claims as the present multi-level and correlational analyses could demonstrate trends only. Should future evidence support the present findings, one could argue that designing effective goals with clients should include shared decision-making where clients can contribute their preferences.

Limitations and further research

The validity of the shared decision-making observation scale was not formally assessed in the present study. However, the design of this observation scale was informed by healthcare and mental health conceptualisations of shared decision-making, as well as measurement tools. The design also drew on the qualitative

findings in the present thesis. For example, that psychotherapy decision-making processes could be more therapist-led or more client-led, whilst remaining shared. Doing so ensured the scale was appropriate for both the intended client sample and a psychotherapy context. It would therefore be beneficial to the quality of the scale to examine convergent validity alongside existing measures from other contexts, such as the OPTION scale (Elwyn et al., 2003) or the DEEP-SDM (Clayman et al., 2012).

The present study was unable to draw on a large data set above the minimum sample of 50 suggested for modelling analyses across two levels (Maas & Hox, 2005). This is due to applying the shared decision-making observation scale to clients' statements from their IPR interviews (Chapter, 4). The use of these statements restricted the sample size to the 14 clients. However, the multilevel method used in the present analysis (Hox, 2010) remains appropriate for the exploratory, longitudinal investigation conducted. Moreover, other styles of model development would have placed too much emphasis on client-level interactions (Hox & Maas, 2005). Therefore, the present study's use of the Hox approach could appropriately consider the interactions of variables at both the client and session level.

The limited sample size may have also contributed to the lack of a significant difference between beta coefficients and their standard errors during model development. Sample sizes below 50 for multilevel analysis can be associated with biased estimates of standard errors at the second level, that in the present study would be at the client level (Maas & Hox, 2005). However, the trends identified in the present analysis are useful as preliminary findings to build an understanding of how shared decision-making interacts with outcome variables. In doing so, the

present analysis offers previously absent directions for shared decision-making research in the context of psychotherapy.

Such further investigations could be to examine the potential impact shared decision-making could have both at the start of psychotherapy treatment and throughout. For example, examining how shared decision-making can affect treatment initially, as well as decision-making later in treatment. These latter decisions could then be examined to see any subsequent impact new shared decision-making could have on outcomes. Doing so would enhance the field's understanding of shared decision-making as an ongoing process and offer indications as to whether shared decision-making is the ideal model of psychotherapy decision-making initially and throughout treatment (Emanuel & Emanuel, 1992).

Conclusion

The present study provided the foundations for a reliable observation scale to gauge how much therapists and clients share decisions in pluralistic therapy. Future works should further determine the psychometric properties of the observation scale and the categories within it. Moreover, adopting a longitudinal, multi-level modelling approach tentatively indicates shared decision-making to be beneficial for anxiety and depression reduction, therapists' perceptions of session effectiveness and satisfactions and therapeutic goal progress. Coupled with the research findings from psychotherapy, mental health and healthcare, the present findings imply shared decision-making to be beneficial to therapeutic work across clients, across treatment.

Chapter seven: General discussion

Summary of findings

This thesis had three aims in examining shared decision-making within adult counselling and psychotherapy. Four investigations contributed towards these aims. These consisted of a systematic review, a Grounded Theory approach to clients' Interpersonal Process Recall interviews, a Conversation Analysis, and a multi-level analysis incorporating a shared decision-making observation scale.

The first aim was to identify the process by which therapists and clients share decisions. Two investigations contributed towards this first aim; the grounded theory of clients' interpersonal process recall interviews and the conversation analysis of goal negotiations. These investigations showed that therapists and clients can take actions to facilitate each other's involvement in decision discussions.

The second aim was to understand how clients experienced shared decision-making. All investigations contributed towards this aim. These studies suggested that clients experienced shared decision-making as a process they wanted to take part in and were often comfortable doing so. They also experienced this process as one that could be led more by either themselves or their therapist.

The final aim was to evaluate the impact of shared decision-making in counselling and psychotherapy. All four investigations contributed towards this third aim. These investigations offered evidence for shared decision-making having a beneficial experiential impact on clients and their treatment. They also showed evidence for a potential beneficial impact on clinical outcomes.

Comparisons to existing conceptualisations of shared decision-making

The adaptation of Coulter and Collins' (2011) shared decision-making definition in Chapter 1 suggests that the approach in psychotherapy consists of: an

ongoing metatherapeutic dialogue in which a therapist and client work together to select therapy directions, methods, or support based on a client's informed preferences, a therapist's expertise, and the clinical evidence when appropriate. The investigations within chapters four, five, and six of shared decision-making in pluralistic therapy supported the adapted definition.

These three investigations showed that therapists and clients worked together to discuss treatment decisions. This working together was evident from clients' reports, observation scale coding ratings, and descriptions of talk in interaction. The decisions dyads made included those regarding how they would work together. For example, whether to use therapy goals, how much to focus on past or present experiences, or how directive the therapist would be. Other decisions included those regarding methods and the content of sessions. Dyads also made structural decisions, such as what time and day to have appointments.

Chapters four, five, and six demonstrated that the way therapists and clients talk during shared decision-making can support the adapted definition of the approach for psychotherapy contexts. These investigations showed therapists invited clients to offer their preferences either verbally or through formal feedback tools. Clients at times also offered their preferences unprompted. There was also evidence of therapists making suggestions using their knowledge of both psychotherapy and their clients. However, there was limited evidence for therapists and clients discussing clinical evidence. When therapists presented clinical evidence, they did so as additional information in response to clients who had difficulty taking part in the decision-making process.

The limited discussion of clinical evidence in the present analyses contrasts with Coulter and Collins' (2011) and Charles et al.'s (1997; 1999) conceptualisations

of shared decision-making. These place the exchange of clinical information at the forefront of the approach, where the aim is often to select a treatment option. For example, Charles et al.'s (1997) propose a discussion of available treatments and their associated benefits or risks as one of four requirements for shared decision-making. Similarly, Coulter and Collins (2011) suggest that clinical evidence and patients' informed preferences are two bases for making shared decisions. As such, the present findings suggest that the shared decision-making in psychotherapy had a reduced emphasis on discussing clinical evidence than that proposed for healthcare.

This reduced emphasis on discussing clinical evidence may be due to less appropriate opportunities to do so in psychotherapy decision-making. The decisions in the present studies often showed dyads constructing a definition of decisions before discussing any options or associated benefits and risks. This contrasts with a healthcare context where the decisions to be made are often pre-defined by a patient's symptoms (Goffman, 1968). For example, the present conversation analysis showed dyads co-constructed relevancies to define therapy goals before discussing their appropriateness for the client's treatment. These decisions were therefore bespoke to those clients. As such, it was more appropriate for the therapist to use their expertise and knowledge of evidence to offer suggestions based on that individual client, rather than discussing clinical evidence based on other clients. When therapists did discuss evidence, they did so implicitly by using general statements of what clients in therapy often find helpful.

The grounded theory and conversation analysis suggest that clients can take actions to facilitate shared decision-making. For example, clients reported in their interpersonal process recall interviews that they felt their openness to their therapists' knowledgeable suggestions was helpful for facilitating shared decision-

making. Similarly, clients in the conversation analysis who co-constructed goal decisions with their therapists acknowledged and demonstrated their understanding of their therapist's suggestions. These clients produced talk following their therapist's suggestions that recognised those suggestions and deemed them to be relevant for goal decisions. Therapists in these instances acknowledged their client's suggestions in the same way. Moreover, clients reported in their interpersonal process recall interviews that their therapist often made recommendations based on that client's previous talk or suggestions. These actions from dyads are aligned with the nature of psychotherapy where the difficulties clients are seeking help for may be identified through joint exploration or interpretations (Bercelli, Rossano, & Viaro, 2008). Together, these findings expand on the adapted definition of shared decision-making to demonstrate that a therapist and client working together goes beyond an information exchange, to include being open to the information offered by the other party.

The shared decision-making process observed by the present studies in psychotherapy showed similar characteristics to Makoul and Clayman's (2006) integrative model. Makoul and Clayman demonstrated essential characteristics of shared decision-making across conceptualisations (Chapter 1). The grounded theory, conversation analysis, and use of the observation scale showed that the shared decision-making in pluralistic therapy contained these characteristics.

However, two of Makoul and Clayman's (2006) essential characteristics for shared decision-making contrast with the process as examined in psychotherapy. First, therapists varied on how often they presented all available options. For example, therapists deciding with their client what day to have treatment sessions could list all available options. In such instances the available options were

predefined and constrained to one of five weekdays. In contrast, dyads creating a client's first therapy goal may have found it more appropriate not to constrain options to a predetermined list. This is likely due to the abstract and open nature of these goal decisions. For example, therapists began goal setting activities in pluralistic assessments with open questions such as 'what do you think would be beneficial for you to get out of-' (Chapter 5). As such, shared decision-making in the present investigations varied in whether option listing was appropriate.

The shared decision-making in pluralistic therapy also differed from Makoul and Clayman's (2006) conceptualisation in how dyads organised follow-up meetings. Therapists suggested to clients that decisions could be revisited later in treatment. However, no formal date or time was organised. This was likely because the pluralistic therapy protocol contained pre-set times at sessions four and ten for dyads to review decisions. Such reviews would have focused on any amendments that could be made to how the dyad was working together, as well as discussing or monitoring any outcomes of those decisions (McLeod & Cooper, 2012).

Makoul and Clayman (2006) further suggest ideal elements of shared decision-making that can enhance the process. These consist of a practitioner delivering unbiased information, defining roles, presenting evidence, as well as both parties reaching mutual agreement. The present analyses showed that shared decision-making in psychotherapy contained these ideal characteristics. For example, mutual agreement was evident from clients' reports during their interpersonal process recall interviews and across all three conversation analysis trajectories. Such agreement was also implied by the characteristics of the three shared coding categories within the shared decision-making observation scale. Defining roles was also evident in the shared decision-making within psychotherapy. The audio

recordings of decision discussions used in interpersonal process recall interviews showed dyads defining their roles through metatherapeutic communication. Defining these roles was also assisted by the Cooper-Norcross Inventory of Preferences (Cooper & Norcross, 2016). This helped clients offer their preferences for how they might work with their therapists, inclusive of decision-making. For example, items asked clients if they wanted to take more of a lead in therapy or have their therapist take more of a lead. Using the tool in this way shares similarities with Elwyn et al.'s (1999) suggestion that determining roles preferences can be an implicit process. Together, these findings imply that the ideal characteristics for shared decision-making suggested by Makoul and Clayman (2006) are common within shared decision-making in pluralistic therapy.

The shared decision-making process identified by the present analyses also shares similarities with Elwyn et al.'s (2017) three-talk model of shared decision-making. This model is a refined version of Elwyn et al.'s (2012) earlier model. The model centres shared decision-making consultations around three types of talk. First, a practitioner should emphasise that a patient has choice in the treatment decision. Second, a practitioner should present options alongside any benefits or risks. Last, a practitioner should guide the patient to form preferences as both parties move towards an agreed decision. Practitioners should then remind the patient that the decision is open to later review, if appropriate. Elwyn et al. (2017) add a greater emphasis on a patient's capacity to make autonomous decisions, the emotional and relational aspects of conducting shared decision-making, and providing that patient with support. The three-talk model has a recurring theme of checking a patient's reactions, thoughts, and knowledge about the decision and information discussed. As such, this revised model moves away a prescriptive approach to shared decision-

making, to have a greater consideration for the relational aspects of the interaction. The present conversation analysis demonstrated evidence in support of the three types of talk. For example, therapists frequently emphasised that patients have choice and that the decision is open to later review. Therapists also often positioned clients as a knowledgeable authority when starting to create goals.

The shared decision-making process that occurred in pluralistic therapy demonstrated that the characteristics of shared decision-making are transferable from a healthcare context to a psychotherapy context. The present analyses also add to the psychotherapy field's understanding of these characteristics. For example, the present studies present new evidence for how clinical evidence is discussed and options presented, the use of therapists' expertise, how dyads arrange follow-up meetings, and how dyads define decision-making roles.

The process by which therapists and clients share decisions in counselling and psychotherapy

Hierarchy of methods to facilitate shared decision-making.

The findings from the present thesis move beyond a conceptual understanding of shared decision-making in psychotherapy to show how that process occurred. The grounded theory showed that therapists could facilitate their clients' involvement in shared decision-making. Therapists did so by encouraging and supporting clients' involvement with four types of actions. First, by therapists creating gaps during their talk for a client to offer input. Therapists also directly referred to clients or invited them to have input. If a client needed additional support to become involved in the decision-making process therapists helped clients to frame their suggestions. Last, therapists acknowledged clients' suggestion, encouraging future contributions. Similarly, the conversation analysis showed that therapists

could use increasingly explicit methods to facilitate client engagement, following continuing misaligning responses. These therapists used scaffolding that included suggestions based on prior or local content, single or lists of candidate answers, and invitations to clients to make suggestions. Using these methods could result in repairs to alignment and both parties co-constructing goal decisions together.

These findings suggest a hierarchy of methods that a therapist can use to facilitate shared decision-making. This hierarchy builds towards more explicit attempts to involve a client, should that client display continuing difficulty in contributing. First, a therapist can leave gaps in their speech for a client to contribute to decision discussions. Should a client not contribute in these gaps, the therapist can explicitly invite the client to make contributions. Therapists can also offer candidate answers. If a client's difficulty continues, the therapist can use scaffolding to build towards questions that increase the authority of that client as the knowledge party that can provide an answer. A therapist in these instances can continue to increase how much an answer is dependent on the client's knowledge. A therapist can also suggest their own lack of knowledge authority to answer a question. If a client continues to display difficulty in contributing, a therapist can help the client to structure those contributions. To do so, the therapist can draw on a client's previous talk from the current or a previous session. This can include outcome measures such as the PHQ-9. The therapist can then use this previous talk to make suggestions for the dyad to discuss. When a client offers a suggestion, therapists can encourage further contributions by acknowledging that suggestion. This can help reassure clients of the appropriateness of their suggestions within the decision-making process.

Post-decision discussions.

The conversation analysis demonstrated that clients can present new decision-relevant information after a goal decision is mutually agreed or written down. Such post-decision discussions contained new information or evidence for the dyad to test the fit of the decision. Therefore, clients can potentially offer evidence that could alter the appropriateness of the previously agreed decision.

The evidence for post-decision discussions builds on healthcare conceptualisations that suggest shared decision-making is an ongoing process. For example, Coulter (2017) propose shared decision-making to be an ongoing process, offering long term care planning as an example. Similarly, Elwyn et al.'s (2017) three-talk model suggests practitioners remind patients that decisions are open to later review. Moreover, shared decision-making interventions have shown that the approach can be performed over multiple meetings, suggesting an ongoing practice (Hamann et al., 2017; Ishii et al., 2017; Paraskeva et al., 2016).

Such post-decision discussions build on the adapted definition's inclusion of ongoing metatherapeutic communication. Cooper and McLeod (2011) state that metatherapeutic communication should be ongoing throughout pluralistic therapy. They also suggest therapists create explicit opportunities for metatherapeutic communication by holding two therapy review sessions at sessions four and ten of pluralistic therapy for depression (McLeod & Cooper, 2012). As such, therapists in the present shared decision-making in pluralistic therapy suggested to clients that decisions can be revised in later sessions. Yet, the conversation analysis suggests that such revisions can occur immediately following a dyad's mutual agreement of a decision. These findings imply that the ongoing nature of shared decision-making is not limited to future sessions, but can also occur in the same discussion, beyond any initial conclusion to the decision-making process.

How clients experienced shared decision-making in counselling and psychotherapy

Clients' preferences for involvement in shared decision-making.

The grounded theory showed that clients in a majority of instances experienced shared decision-making as a process they were immediately comfortable taking part in. At other times, clients became comfortable after additional encouragement or support from their therapist. This comfortableness is also implied by the conversation analysis trajectories where clients adopted more of a lead or co-constructed their goal decisions with their therapists. Clients in these two trajectories showed little evidence of difficulty in contributing to decision negotiations.

These findings are aligned with the clients' and patients' reports of the approach as desirable. For example, patients in the United Kingdom reported wanting to be more involved in the decisions around their care and wanting to have more treatment options available (Ahmad et al., 2014; Edwards, 2001). Similarly, psychotherapy clients have reported wanting to be involved in treatment decisions and felt they should have the opportunity to do so (Adams, 2007; Kenny, 2012; Sundet, 2011). The present analyses move beyond these findings to suggest that clients not only want to be involved in decisions around their care, but would be comfortable contributing to decision discussions when given the opportunity.

One explanation for clients wanting to be involved and being comfortable doing so is that they have preferences they want to voice. Williams et al. (2016) examined the preferences of a cross-sectional sample within United Kingdom public psychological treatment. They found that most patients expressed at least one preference for their treatment. As such, shared decision-making likely provides a platform for clients to offer these preferences.

Clients in the grounded theory also reported in a minority of instances that taking part in the shared decision-making process was initially daunting. This daunting feeling shares similarities with the conversation analysis trajectory whereby a client demonstrated minimal engagement with the decision-making process. The therapist in these instances would take more a leading role in goal negotiations, as the client continued to show minimal engagement and present misaligning responses.

This minimal engagement contrasts with Charles et al.'s (1999) conceptualisation of shared decision-making. Charles et al. (1999) proposed an update to their earlier conceptualisation regarding the information exchange and deliberation between practitioners and patients. This update added that both parties should be willing to engage in decision discussions to be deemed a shared process. However, clients in the present investigations that experienced difficulty contributing to the decision-making process were likely not unwilling, but needed additional support to participate. To illustrate, clients demonstrated that they wanted more information from their therapist (Chapter 4) or displayed difficulty defining goal content (Chapter 5). Moreover, the clients taking part in the present pluralistic therapy did so of their own accord, following a referral from the University's Well-being Team. This suggests that the clients already held a willingness to seek help with their difficulties they were experiencing. These clients were also required to meet to an inclusion criteria at assessment of having a having an aspect of their life they would like to improve. Therefore it is logical to assume that although a client's actions could be seen as a lack of engagement, they were more likely indications of a need to work with their therapist to define or understand what their difficulties were, how they might tackle those difficulties, and what they might want from treatment overall.

The differences in clients' experiences feeling comfortable or daunted when given the opportunity to take part in decision discussions suggests that clients can have differing preferences for roles within shared decision-making. This supports suggestions that practitioners should ask patients how much involvement they want in decision-making, offering them more or less autonomy (Elwyn et al., 2000; Borrell-Carrio et al., 2004; Towle & Godolphin, 1999;). Similarly, shared decision-making tools include items to ask patients how much involvement they want in their decision-making process with their practitioners (Feenstra, 2012; O'Connor, 1995; O'Connor et al., 1998).

The same clients who reported feeling daunted or showed minimal engagement also reported instances of shared decision-making they were comfortable taking part in. These mixed reports across decisions suggest that clients' preferences for involvement can vary across decisions. These differences in preferences can be explained by the varying complexity of decisions likely to occur in psychotherapy. For example, a client may find administrative decisions less daunting, such as a decision about what time to have their treatment. These decisions do not contain abstract content and would have external determinants such as therapist and client availability. In contrast, a client may experience a greater daunting feeling when deciding an aspect of their life they would like to change and use as a goal for treatment. These latter decisions are likely more complex than administrative decisions as the dyad would have to define the goal before negotiating its appropriateness. An example could be designing a goal to improve a client's mood. Such a decision would contain more abstract content or have internal determinants such as what the client believes attainment or progress towards that goal would look like.

Continuum of decision-making.

The protocol for the pluralistic therapy in the present investigations encouraged therapists to practice shared decision-making (McLeod & Cooper, 2012). Clients corroborated therapists' attempts to perform shared decision-making through their reports in their interpersonal process recall interviews. These clients felt they experienced instances of decision-making with their therapist that were shared. These clients also experienced shared decision-making at times as being led more by themselves or their therapist. Similarly, the conversation analysis trajectories for goal negotiations showed separate instances of both clients and therapists adopting more of a leading role in decision negotiations. The ratings from the shared decision-making observation scale also demonstrated that instances of shared decision-making could be coded as shared or shared, but led more by a therapist or client.

The findings showing that therapists could take more of a lead in shared decision-making share similarities with findings from psychotherapy research. For example, Chong et al. (2013) showed that mental health practitioners see shared decision-making as desirable, but that some patients may need the practitioner to take more of a lead in the process. Chong et al. (2013) report 31 mental health practitioners' perspectives of shared decision-making in hospital and primary care settings. The sample included but was not limited to psychiatrists and psychologists. The sample supported the practice of patient involvement through shared decision-making. Yet, these practitioners felt their patients should hold a capacity to participate in the decision-making process and make informed decisions. Practitioner's evaluated this capacity by a patient's degree of insight into their mental health condition. Practitioners felt more directive techniques were appropriate

in decision-making after evaluating a patient as having limited capacity. Similarly, Osei-Bonsu et al. (2016) report practitioners took more of a lead in shared treatment decisions. These practitioners did so by using their knowledge of their clients to pre-judge those clients' capacity to engage in treatments. Together, the present findings alongside those from Chong et al. (2013) and Osei-Bonsu et al. (2016) imply that some shared decisions could benefit from greater therapist influence. Such findings are aligned with perspectives of shared decision-making practice for helping professions that suggest the approach may not always be truly shared. Barry and Edgman-Levitan (2012) suggest that some decisions have one superior option, offering the example of a fracture that subsequently needs repairing. Similarly, if a client taking part in treatment for depression is seeking help for difficulties in preventing themselves from fatal self-harm, a clear decision path for a helping professional would be to work towards preventing a fatal outcome for the client. As such, there are likely instances where truly equal shared decision-making may be difficult to use in practice, or the decision may benefit from leaning towards being influenced more by a practitioner or client.

The findings from the present analyses also support research findings suggesting shared decision-making can be led more by either a therapist or client (Quirk et al., 2012; Slade, 2017; Towle et al., 2005). As such, these findings also support Cooper and McLeod's (2011) proposed continuum of decision-making in psychotherapy from therapist-led, to client-led, with entirely shared as a mid-point. However, therapists taking more of a lead in shared decision-making should ensure clients remain involved in that process. Doing so ensures clients remain involved in the process and the decision-making does not become a paternalistic interaction (Emanuel & Emanuel, 1992). This shares similarities with Sundet (2016) who

suggests both therapists' and clients' contributions within shared decision-making should be seen from an egalitarian standpoint. This standpoint should remain, despite recognising that each party holds a different role in the decision-making process. Doing so would ensure that both parties remain involved in the decision-making process when circumstances might call for a more therapist-led approach.

Discrepancy between intentions and practice.

The present thesis' findings suggest that attempts to perform shared decision-making may not always result in it occurring. The systematic review showed that there could be a discrepancy between practitioners' intentions to perform shared decision-making, and the amount this practice occurred. This review also showed that not all instances of decision-making were shared within psychotherapy services in the United Kingdom and United States. Similarly, clients in their interpersonal process recall interviews reported that not all decisions in their pluralistic therapy were shared. Such reports contributed to early categories of grounded theory analysis. These were removed at later stages of analysis for not contributing towards a structure relevant to the investigation of shared decision-making. The multi-level analysis findings and the use of the shared decision-making observation scale also support these findings. Eight clients were coded as having at least one decision that was therapist led, although no averages for any client indicated entirely therapist-led decision-making. However, the frequency with which decisions were coded as shared throughout the investigations of chapters four, five, and six was greater than those with a single leader only. Therefore, these findings suggest that most instances of decision-making in the present pluralistic treatment were shared, but not all.

These findings share similarities with those suggesting that healthcare practitioners' attempts to perform decision-making may not always be successful.

For example, that general practitioners thought they used more shared decision-making than the amount that met all of the requirements for shared decision-making proposed by Charles et al. (1997) (Charles et al., 2003; Stevenson et al., 2000). Later observations of general practice consultations showed that the decisions within them were generally practitioner-led, although some practitioners did work with clients' preferences (Ford et al., 2006). Moreover, mental health practitioners and therapists have been shown to lead decision-making by limiting client input (Antaki et al., 2006), or lead negotiations following clients' weak or vague responses (Ekberg & LeCouteur, 2014). Together, these findings and those from the present analyses imply that therapists seeking to practice shared decision-making should be aware that they could lead the process more than they intend.

The impact of shared decision-making in counselling and psychotherapy

Clinical outcomes.

The systematic review found limited evidence regarding a positive relationship between shared decision-making and clinical outcomes. However, the multi-level analysis showed trends towards shared decision-making being associated with reduction in anxiety and depression symptoms across pluralistic therapy. This multi-level analysis finding is unique within this thesis as the qualitative works did not examine longitudinal impact across all sessions. These mixed findings for the impact of shared decision-making on clinical outcomes have also been found in reviews of healthcare and mental health literature. The findings of such reviews showed both no evidence of an effect of interventions on clinical outcomes, and positive impact that included long term effects (Duncan et al., 2010; Joosten et al., 2008).

The present findings for shared decision-making and clinical outcomes indicate the potential for a positive relationship between the two variables. However, the mixed nature of these findings suggests this relationship may not be straightforward or have other variables that moderate or mediate the relationship. Hessinger, London, and Baer's (2017) examination of shared decision-making interventions can help explain these relationships. They examined archival data of veterans in a post-traumatic stress disorder outpatient clinic. This outpatient clinic had implemented a shared decision-making intervention as part of regular clinic practice. Hessinger et al. showed that clients that had taken part in the shared decision-making intervention were more likely to initiate treatment sooner than those who did not. These two groups of clients did not differ on treatment completion. These findings suggest that shared decision-making is associated with a willingness or readiness to initiate treatment. Such willingness has implications for effective treatment, with 40% of therapeutic change estimated to be attributable to client or extratherapeutic factors (Lambert, 1992; Sprenkle & Blow, 2004; Thomas, 2006). This is in comparison to estimates for relationship factors at 30%, as well as both client expectancy and type of treatment model or techniques at 15%. Client factors include the personality of the client, as well as their strengths, faith, and persistence (Hubble, 1999; Sprenkle & Blow, 2004). Wampold (2015) advances on these estimates to show that 13% of total the variance in therapeutic outcomes can be explained by treatment factors. This leaves client or extratherapeutic factors, unexplained variables, and error able to account for 87% of variance in treatment outcomes. Therefore, these findings imply that clients taking part in shared decision-making are likely more ready or willing to make change and subsequently could experience better treatment outcomes.

Another potential mediator between shared decision-making and clinical outcomes may be the therapeutic alliance. The present systematic review showed shared decision-making interventions were associated with increased therapists' ratings of the working alliance at the start of treatment. Doran et al. (2012) have also shown higher therapeutic alliance ratings to be associated with greater collaboration and a collaborative bond (Doran et al., 2012). Similarly, both the concepts of the therapeutic alliance and shared decision-making contain similar characteristics, including: accommodation of clients' wants, mutual agreement, and therapist-client collaboration (Bachelor, 2013; Doran et al., 2012; Horvath & Greenberg, 1989). Given these similarities, actions within shared decision-making would likely also contribute towards the therapeutic alliance. Moreover, Bohart (2000) proposes that collaborative approaches that engage the client in therapy processes are better for developing a good therapeutic alliance and therefore successful treatment. Other research examining therapeutic alliances or relationships showed that higher quality alliances can positively impact the therapeutic work (Norcross, 2011, Wampold, 2015). Therefore, shared decision-making could likely indirectly impact clinical outcomes through impacting the strength of the therapeutic alliance.

As such, further research should confirm any impact shared decision-making can have on clinical outcomes. In doing so, it would be useful to the field to understand whether shared decision-making and clinical outcomes have a direct relationship, or whether moderating or mediating variables exist between them. For example, whether client readiness and willingness to engage in treatment or the strength of the therapeutic alliance can mediate the relationship between shared decision-making and clinical outcomes.

Experiential and ethical benefits.

The present analyses showed experiential benefits for clients in taking part in shared decision-making. The systematic review showed shared decision-making interventions to be associated with reduced client arousal and reduced client hostility. The grounded theory showed that clients felt they were listened to and understood by a therapist that accommodated for their needs and preferences.

Accommodating for clients' needs and preferences is aligned with the ethical and best practice guidelines for counselling and psychotherapy in the United Kingdom. For example, the wider recommendations for helping professions that propose patients are entitled to care that accommodates for their reasonable needs (NHS, 2015). The present findings also support recommendations for psychotherapy that practitioners be aware of the range of beliefs and values clients could bring to treatment and how those clients may be experiencing the treatment (BACP, 2016; UKCP, 2009). Moreover, this accommodating for client's preferences is aligned with NICE guidelines for the treatment of depression. NICE's (2009) guidelines suggested clients have a right to be involved in their treatment decisions. Later developments to these guidelines recommend that clients should be able to give informed consent that they want to take part in collaborative decision-making (NICE, 2017). Therefore, the shared decision-making that clients experienced in the present pluralistic therapy was in accordance with guidelines for ethical and best practice for counselling and psychotherapy.

The multi-level analysis offered preliminary evidence that more shared assessment decisions could be positively associated with therapy goal progress. This analysis showed a trend towards more therapist-led assessment decisions being associated with lesser rates of goal progress over treatment. These findings imply that these assessment decisions were less shared or client-led. Moreover, such

therapist-led decisions potentially had less involvement from the client. Such assessment decisions would have included goal decisions. As such, this finding suggests that clients likely made slower progress towards their therapy goals than if they had contributed more towards the design and negotiation of them.

These multi-level findings are further aligned with guidelines for ethical practice within counselling psychology in the United Kingdom. BPS (2005) guidelines state that a practitioner should support clients' autonomy by helping them to make appropriate decisions. UKCP (2009) also encourage therapists to recognise and respect their clients' autonomy to engage with treatment. Similarly, Slade (2017) proposes that practitioners see shared decision-making practice as ethical because it accommodates for a human right to self-determination that implies the appropriateness of 'full involvement in decisions affecting the person' (p. 147). As such, the present findings offer further support that the shared decision-making clients took part in during their pluralistic therapy was aligned with ethical practice.

The indicated experiential benefits of shared decision-making can have implications for clinical outcomes. The grounded theory showed that clients felt the decisions resulting from shared decision-making were useful for themselves and their therapy. These findings support the works of Swift and Callahan (2009) that showed accommodating for client preferences can positively affect clinical outcomes and patient adherence. They showed that clients matched to their treatment preference were less likely to drop out of treatment and showed greater improvement than those not matched to their treatment preference. Moreover, Tryon and Winograd (2010; 2011) showed a positive relationship between goal consensus and therapy outcome. They present two meta analyses of goal consensus and collaboration. First, they showed from 15 studies ($N = 1,302$) that goal consensus

had a small to medium effect size on treatment outcome. Second, Tryon and Winograd showed from 19 studies ($N = 2,260$) that goal collaboration had a small to medium effect size on treatment outcomes. DeFife and Hilsenroth (2011) further suggest collaborative goal decisions to be one of three factors in early psychotherapy practice associated with favourable treatment outcomes and adherence. As such, the experiential benefits clients experienced in taking part in shared decision-making may be associated with clinical outcomes and treatment adherence. Further research should explicitly examine shared goal decision-making at the start of treatment and any enduring impact this can have on favourable treatment outcomes.

Together, the present findings show shared decision-making to be associated with experiential benefits. These benefits imply the approach is aligned with ethical and best practice guidelines for counselling and psychotherapy in the United Kingdom. Further, these experiential benefits are likely associated with further positive impact on clinical outcomes and treatment adherence.

Session effectiveness.

The systematic review showed clients were satisfied with the shared decision-making intervention they took part in (Mott et al., 2014). The conversation analysis supports these findings. Clients in all three trajectories mutually agreed goal decisions with their therapist, suggesting an implicit satisfaction with those decisions. Such indications of satisfaction are further implied by clients' positive appraisals of their shared decision-making experiences during their interpersonal process recall interviews. However, the multi-level analysis did not find any positive indication of shared decision-making impacting clients' evaluations of satisfaction and session effectiveness.

This lack of a positive indication with client satisfaction within the multi-level analysis did not provide support for existing evidence. For example, patients who had taken part in a shared decision-making intervention had greater treatment satisfaction than control groups (Ishii et al., 2017; Loh et al., 2007; Paudel, Sharma, Joshi, & Randall, 2018). Together, the present qualitative findings alongside Mott et al. (2014), Ishii et al. (2017), Loh et al. (2007), and Paudel et al. (2018) suggest a likely positive relationship between shared decision-making and client satisfaction. Therefore, further research should examine the possibility of such relationship.

The multi-level analysis showed a trend towards shared decision-making having a positive impact on therapists' ratings of session effectiveness and satisfaction. These findings tentatively support healthcare practitioners' positive appraisals of shared decision-making. For example, practitioners reported holding positive attitudes towards shared decision-making during and after using the approach (Castillo-Tandazo et al., 2016; Pollard et al., 2015; Towle et al., 2005). Similarly, mental health practitioners reported being more satisfied with the treatment received by patients who had taken part in a shared decision-making intervention, than patients in a control group (Hamann et al., 2006; Leblanc et al., 2015). This increased satisfaction could be due to the shared decision-making process recognising both practitioner and client knowledge in creating treatment decisions (Charles et al., 1997; 1999; Coulter & Collins, 2011). Such a process would ensure any final decisions fit both a practitioner's professional opinion and a patient's preferences.

Shared decision-making interventions being associated with practitioner satisfaction would have implications for the uptake of the approach within psychotherapy services. For example, if future evidence supports such a positive

relationship, practitioners that have not used the approach before may be more inclined to do so beyond their first attempts. This would assist with practitioners' feelings of apprehension in initially implementing shared decision-making into their practice (Abrines-Jaume et al., 2014). Such favourable perception of shared decision-making could in turn be advantageous to the amount of resources psychotherapy services direct towards promoting shared decision-making or training practitioners in the approach.

Implications for shared decision-making practice in counselling and psychotherapy

This thesis presents evidence that has implications for practitioners using shared decision-making in counselling and psychotherapy. For example, that the characteristics of shared decision-making in healthcare are transferrable to a psychotherapy context. However, there are additional considerations when practicing shared decision-making in psychotherapy. The differences in these conceptualisations suggest that practicing shared decision-making may not be a simple practice of including a list of characteristics within discussions. The qualitative findings in this thesis suggest nuances to the way in which shared decision-making can be performed in counselling and psychotherapy. First, it would be appropriate to place less of an emphasis on discussing clinical evidence, and more on a therapist using their expertise. A therapist would likely find it helpful to use their psychotherapy expertise and knowledge of their client to offer suggestions, rather than discussing clinical evidence based on other clients. Doing so aligns with the subjective nature of difficulties clients often seek help for in psychotherapy because clinical knowledge can often be more vague or uncertain, in comparison to medical settings. Here, therapists should be aware that clients displaying of a lack of

engagement in these contexts may more likely be indicating a need for support in the decision-making process. Second, therapists should be aware of the ongoing nature of shared decision-making and how they might review decisions with their clients later in treatment, or immediately following an initial conclusion to that decision. Therapists in the present pluralistic therapy often expressed to clients that decisions could be revisited at a later point, without organising a formal time to do so. This is likely due to the pluralistic treatment protocol predetermining a time for dyads to revisit decisions during therapy review points at sessions four and ten. As such, therapists intending to practice shared decision-making in protocols without therapy review points could benefit from suggesting a time to review decisions. Such therapists could also draw on metatherapeutic communication at the beginning and end of treatment sessions to review decisions. As such, this thesis suggests shared decision-making in counselling and psychotherapy can be a complex process that can differ in how the characteristics of shared decision-making are prioritised from one client to the next, across therapists, contexts, and discussions.

The present studies also showed that therapists can potentially lead the shared decision-making process more than they might initially intend. To accommodate for unintentionally leading decisions, therapists could maintain an awareness of how they present suggestions to their clients. This would accommodate for Charles et al.'s (1997) recommendation for practitioners to be mindful of imposing their views during deliberation. To do so, therapists could avoid listing options after a client suggests their preferred choice (Antaki et al., 2008). This would avoid deemphasising the choice a client has made. Moreover, therapists could offer options and suggestions without extreme case formulations or indications of one suggestion as unsatisfactory (Reuber et al., 2015).

This thesis showed that clients can differ in their preferences for how much involvement they have in the shared decision-making process. These preferences can also differ for the same client across decisions. Therapists seeking to practice shared decision-making should try to accommodate for these potential differences in preference. Therefore, it would be useful for therapists to see shared decision-making as a flexible approach that can be adapted to each client. Clients taking part in pluralistic therapy have reported such flexibility as a helpful therapist related factor (Cooper et al., 2015). Such flexibility reinforces the appropriateness of an ongoing metatherapeutic communication between a dyad to discuss preferences and alter the shared decision-making process accordingly.

A therapist trying to elicit a client's preference for involvement may find it helpful to draw on formal feedback tools and metatherapeutic communication. For example, therapists in the present pluralistic therapy used the Cooper-Norcross Inventory of Preferences to elicit client preferences before decision-making (Cooper & Norcross, 2016). A therapist could also find it helpful to open metatherapeutic dialogue with their client throughout treatment. Such dialogue would help to determine how the client is experiencing the shared decision-making process and any changes they would like to make. To illustrate, a client could indicate in their assessment session that they would like decision-making to be shared, but more therapist-led. That client's preference may change as they become more familiar with the therapeutic process and as the therapeutic alliance develops. Through metatherapeutic communication at the beginning of a treatment session, a therapist could learn that the client now prefers that decision-making be equally shared or led more by themselves.

This thesis showed that therapists can use methods during decision discussions to help clients make contributions and thereby facilitate a shared decision-making process. First, a therapist can draw on a hierarchy of actions to help a client present their opinions and suggestions. The methods throughout this hierarchy draw on a therapist's knowledge of the client and psychotherapy knowledge of what might be helpful for that client's difficulties. These methods build towards more explicit attempts to involve a client, should that client display continuing difficulty in contributing. For example, a therapist can leave gaps in their speech for a client to offer talk or directly invite that client to contribute. For a client who display more difficulty, a therapist can help that client structure suggestions by drawing on prior content or suggest that the client is better placed than the therapist to provide a suggestion. Second, a therapist can reopen decision discussions after both parties have mutually agreed a decision. The present evidence showed that clients can offer new information or evidence during post-decision discussions. This information was often used to test the appropriateness of the decision. Reopening these discussions after agreement could accommodate for any information that a client may have not thought to mention or chose not to present during the shared decision-making process. Doing so ensures that both parties see the final decision as appropriate for meeting a client's needs.

General limitations

Each original investigation in the present thesis contains a discussion of their individual limitations, although the thesis has four general limitations. First, clients' evaluations could have differed on the actions that led them to perceive the decision-making process as shared. The three investigations in chapters four, five, and six all drew on these client evaluations. To illustrate, a client during their interpersonal

process recall interview could perceive their therapist's questions as an invitation to offer knowledge or opinion. Whereas, another client saw their therapist's questions as a method to gather information for that therapist's own purposes.

Additional grounded theory approaches could accommodate for this potential inconsistency across clients' evaluations. Charmaz's (2001) approach to grounded theory proposes analysts draw on their own interpretations as well as primary transcript data. This approach would have enabled an additional, constant perspective across all examinations of client transcripts. However, the present grounded theory analysis aimed to adhere closely to clients' perceived experiences. The methods in later chapters could accommodate for this potential inconsistency. For example, the observation scale used pre-determined criteria to objectively rate client's reports. Moreover, the conversation analysis described talk in interaction between therapists and clients from an analytical stance outside of a dyad's evaluations of the decision-making process.

Second, the quantitative investigations evaluating the relationship between shared decision-making and psychotherapy outcomes were limited by their small sample size and low statistical power. The systematic review contained two studies that were not adequately powered throughout the duration of their investigations, with one study presenting descriptive findings only. Similarly, the multi-level models contained 14 participants only. This constraint was due to applying the shared decision-making observation scale to clients' statements from their IPR interviews. Therefore, these investigations cannot conclude a positive relationship between shared decision-making and psychotherapy outcomes, nor conclude the absence of a relationship. As such, these findings can offer potential positive indications only.

Third, there may be claims to limitations of the generalisability of the thesis findings. This is due to the three original investigations taking place within a single approach to psychotherapies. However, it was valuable to conduct this study within the practice of pluralistic therapy; an integrative approach with an emphasis on shared decision-making that draws on a range of methods across therapeutic approaches (Cooper & McLeod, 2011). In doing so, this thesis likely had greater opportunities to examine moments of shared decision-making than in another therapeutic approach without such an emphasis. Additionally, characteristics of shared decision-making that are present in other concepts such as the therapeutic alliance are suggested as common factors across therapeutic approaches (Hubble et al., 1999). Therefore, it is plausible that the shared decision-making observed in the current pluralistic practice could be transferrable across therapy orientations.

Fourth, the findings from multi-method approach using three analytical methods could be criticised for lacking depth that could be obtained by performing multiple investigations with the same or similar methods. However, this thesis has been able to build a holistic understanding of shared decision-making by using differing methods. To illustrate, the grounded theory showed clients experienced shared decision-making as more client led, therapist led, or equally shared. Similar findings emerged from the conversation analysis that showed clients and therapists could take more of a leading role in decision negotiation. A shared decision-making observation scale was then used to examine these different types of decision-making. In doing so, this thesis built a comprehensive understanding of a continuum of decision-making influence and leadership.

Further, using this multi-method approach helped accommodate for potential limitations that may have occurred from using a single method, examining a single

perspective. For example, the grounded theory was based on clients' retrospective perspective of the interaction. The data informing this analysis would therefore be susceptible to limitations regarding recollection and subjective evaluations of events. This could include clients recalling positive experiences as better than they were (Jefferson, Bortolotti, & Kuzmanovic, 2017) or recalling negative events more readily than positive events (Ito, Larsen, Smith, & Cacioppo, 1998; Rozin & Royzman, 2001). As such, conversation analysis and an observation scale were used to gain two additional, objective perspectives of decision-making interactions. One examined the decision-making as it occurred, in situ, and the other applied coding criteria that was separate to the interaction's participants. Having these three perspectives therefore supported the accuracy of the findings generated by each.

Future research

The present thesis did not include a focused examination of therapists' perspectives on shared decision-making. However, chapter six offered preliminary indications using the therapist version of the Session Effectiveness Scale. Moreover, research in healthcare and mental health settings have examined practitioners' perspectives on the approach. Yet, the present systematic review shows less findings are available regarding therapists' perspectives of the approach within psychotherapy contexts. It would therefore be useful to the field to examine therapists' experiences of shared decision-making. To do so, researchers could conduct inductive qualitative and quantitative analyses. Such analyses would be directly comparable to clients' experiences in this thesis. For example, whether therapists and clients experience similar actions as helpful for facilitating a shared decision-making process.

The psychotherapy field could also benefit from a comparison between clients who experienced shared decision-making and those who did not. To do so,

researchers could compare psychotherapy outcome and process data from clients taking part in a shared decision-making intervention at the start of treatment, and from a treatment as usual group. Such future studies should contain a sample size for each comparator group appropriate for enabling examination in later treatment. This would accommodate for limitations to statistical power found in the present quantitative investigations. Any findings generated could be compared with the quantitative trends and qualitative indications found in the present analyses of beneficial clinical and experiential outcomes. Part of such future works should also examine the range of trajectories for shared decision-making reported by clients, as well as demonstrated by the conversation analysis and shared decision-making observation scale.

Concluding statement

This thesis pursued three research aims through four investigations of shared decision-making in pluralistic therapy for depression. By meeting these aims, this thesis contributes to the understanding of the conceptualisation and practice of shared decision-making within psychotherapy. In doing so, this thesis offers evidence-informed, practical recommendations for using the approach in psychotherapy. These investigations demonstrated that the characteristics of shared decision-making within healthcare and mental health are transferrable to a psychotherapy context. However, these contexts differ in how much dyads discuss available options and clinical evidence, as well as in when decisions are reviewed as part of an ongoing decision-making process. Therapists practicing shared decision-making can take actions to facilitate the approach with clients who either feel comfortable or daunted in taking part in decision discussions. These clients can have different preferences for their roles in shared decision-making. These preferences

can also differ for the same client across decisions. Therapists should be aware that they or their clients can take more of a lead in the shared decision-making process. Future investigations should compare these differing shared decision-making styles. Moreover, the thesis findings indicated experiential benefits for clients taking part in shared decision-making, as well as the potential for the approach to have a positive impact on clinical outcomes. Thereby, this thesis offers both an ethical and clinical incentive for performing shared decision-making in counselling and psychotherapy.

Appendices

Appendix A: CREST Research Clinic Information sheet and Consent Form

Appendix A1: Client information sheet.

Pluralistic therapy for Depression (PfD)

Pilot Protocol

Information sheet

Many of us have times in our lives when we would like to feel happier. We may:

- feel sad, anxious, stressed, frustrated or overwhelmed
- feel dissatisfied with our work or our relationships
- want to come to terms with a loss or with past experiences
- want to develop our strengths, contribute more to our communities, or find more meaning and purpose in our lives.

Whatever it is that we want to be different, therapy may be able to help. Therapy gives people an opportunity to focus on things that are concerning them and find ways of improving their lives.

This information sheet tells you about the therapy that is being offered as part of the ‘Pluralistic therapy for Depression’ study. Pluralistic therapy is an ‘integrative’ form of therapy, which means that it draws on a number of different therapeutic methods, depending on the training of the therapist. However, what makes it unique is that it tries to develop a strong collaborative partnership with the client, in which the therapist and client work closely together to identify the methods that will be most helpful to that particular individual.

The therapy that is being offered within this service is part of a research project, and this means that you will be asked to complete some questionnaires, be interviewed about your experience of the therapy, and have the sessions recorded. Aside from this, the quality or nature of your therapy will not be affected in any way.

What is pluralistic therapy?

Pluralistic therapy starts from the assumption that different people may be helped to feel happier in different ways, and that this is dependent on a variety of factors, in particular:

- The reason(s) why a particular person feels depressed in the first place
- The person's particular personality, their background, and their current life circumstances
- The person's strengths and positive qualities
- The sorts of things that, in general, have helped that person feel better or worse in their life.

Because this therapy assumes that different people may have different needs and preferences, the first meeting is an 'assessment' session with a therapist, in which you can talk a bit about your background, what has made you interested in coming to therapy and what you would want from it. If you decide you want to go ahead and start therapy, and if your therapist feels that they may be able to help you, he or she will work with you to try and help you identify what may be useful to do. This could include such activities as:

- Understanding what has happened to you in the past that might have led you to feel depressed
- Learning to be more 'yourself' and less concerned about what others think of you
- Learning to think about things in a more positive way
- Changing your behaviour so that you do more of the things you enjoy, and less of the things you don't
- Finding ways to improve your relationships with others
- Finding more meaning and purpose in your life
- Coming to terms with painful experiences, feelings or losses.

If you and the therapist agree not to work together, the therapist will suggest other services that may be more appropriate for your needs. If after the assessment you would prefer to work with someone else, apart from the therapist who assessed you, we will endeavour to refer you another therapist within the project.

More information on pluralistic therapy can be found at www.pluralistictherapy.com

How many sessions will I be offered and how long do they last?

We can offer you a maximum of 24 sessions, which would normally take place once a week.

Your first, 'assessment' session will be up to 90 minutes, and the subsequent sessions are 50 minutes each.

What is the cost?

You will not have to pay for participating in the therapy (and you will not be paid for your participation).

Where will therapy take place?

The therapy will take place at Parkstead House, Whitelands College, University of Roehampton.

Who will my therapist be?

Your therapist will either be an experienced trainee psychologist, closely supervised by a fully qualified therapist; or a fully qualified psychotherapist, psychologist or counsellor. Please note that the therapist will be a staff member or experienced trainee psychologist at the University of Roehampton. You will be told the name of the person who you will be meeting for the assessment session. In the unlikely event that you know this person, please let us know and we will allocate you a different therapist.

What does the research involve?

Pluralistic therapy for Depression draws on a wide variety of tried-and-trusted therapeutic methods for helping people feel better in their lives. Initial research shows that, on average, it is associated with reductions in symptoms of depression. However, there is still much to learn about what kinds of methods may be most helpful for particular people, and how the therapeutic approach can be tailored as effectively as possible for the individual client. For this reason, we are not only offering Pluralistic therapy for Depression, but also studying it, so that we can contribute to the development of this approach.

At the beginning of your initial assessment session, the interviewer will go over the study and answer any question you have. You will then be invited to sign an informed consent form to indicate your agreement to participate in the study.

The research component of this study means that, as part of the therapy, you will be invited to complete a few questionnaires at the initial assessment session, and before and after each therapy session (approximately ten minutes per session). This will be done on a hand-held electronic tablet device, using the secure online data management system, Pragmatic Tracker. You will be given full instructions on how to use this device, and your therapist will always be available to support you in its use. These questionnaires will ask you about your goals for therapy, what kinds of therapeutic methods you might prefer, what you found helpful and unhelpful in the therapy, your level of psychological wellbeing, and your general experience of the therapy.

In addition, following your assessment session, you will be invited to attend an interview with a researcher (about two hours in length), in order to help us understand your experience of the beginning of the therapeutic process. The researcher for this interview will not be a qualified therapist, and this will not be a therapy session, but an opportunity to reflect on the therapeutic process itself. Subsequently, you will be asked to participate in a briefer follow-up interview with the researcher (after about five sessions), and a ‘debriefing’ interview at the end of the therapy.

We will also ask to electronically record each of the therapy sessions using an encrypted audio recording device. You can choose to have this turned off at any point during your therapy.

Participants have the right to decline to participate in any, or all, aspects of the research project at any point in time, and do not need to provide reasons for doing so.

The research project welcomes clients as active participants in the research, and any feedback on the research process, or suggestions for developing the research (for instance, clients may want to write about their personal experiences of the therapy) are very welcome. Copies of all materials will also be available to clients on request.

If you are a student at the University of Roehampton, please note that there is no compulsion or pressure for you to take part in the project as a client. Should you choose to take part and subsequently withdraw, your course marks will not be adversely affected in any way.

Who can participate in this project?

This research project is open to anyone over the age of 18 who is experiencing moderate, or more severe, levels of depression. This will be assessed at your initial appointment. If you do not meet this criterion, we will discuss with you about alternative sources of support that may be available for you. To ensure people get the most appropriate treatment, we will also refer on people who are experiencing psychosis, very severe personality disorders, or drug and alcohol addictions.

What are the benefits and risks of participating in the research?

The potential benefit of participating in this research is that it may help you feel happier and less depressed. Previous research found that around 70% of clients felt better after participating in this therapy.

In participating in this research, you will also be contributing to the improvement of therapeutic methods, and helping us to understand more about what may be of most value to clients.

The potential risk of participating in this study is that therapy may leave you feeling worse. Research indicates that 10% of clients can deteriorate as a result of participating in therapy. In the event that clients feel worse as a result of therapy and

would like to talk to someone other than their therapist about it, they can talk to an independent therapist who has agreed to act as an initial contact point for further support (see details at the bottom of this form).

Participants may experience some boredom, irritation or other negative feelings when completing some of the forms. They may also feel self-conscious when having sessions recorded.

Pluralistic therapy is a relatively new approach, and while it draws on a range of established methods, some of the tools, measures and techniques are in the early stages of development. This means that, while they are intended to be of therapeutic benefit, their impact and value is not yet clear.

For staff and students at the centres where this study is taking place, participation or non-participation in this study will not affect, in any way, your position at the University.

How confidential is the therapy?

As with all therapy, there is a great emphasis in the project on ensuring the maximum possible levels of confidentiality for clients. Material shared by clients – either for the therapy or for the research – will not be communicated outside of the therapeutic environment in a way in which the client is personally named, except where the client explicitly requests it and with their consent. The only exception to this is in circumstances where a risk of serious harm to self or other is disclosed. In these circumstances, the therapist will make every effort to discuss this with the client and identify a mutually agreed way forward before any further actions are taken. If the participant is a student at the University of Roehampton, the therapist will also inform an appropriate contact person at the University's Health and Wellbeing Advice & Counselling services/multi-disciplinary case review group, such that appropriate university measures and procedures can be implemented. We will ask you for contact details of your GP, who may also be contacted where risk of serious harm is indicated.

All therapists within the project are in regular supervision, and recordings of sessions or other details of the therapeutic work may be shared with supervisors, or members of a supervisory team.

In addition, participants will be asked for permission that audio recordings of the sessions can be used for teaching and demonstration purposes.

Anonymised data, including transcripts from therapy sessions, responses to questionnaires and interviews, and case descriptions, may be used in full or part for published output, such as journal papers or book chapters. They may also be used by trainees for case study submitted in partial fulfilment of their course requirements. In these instances, every effort will be made to ensure the absolute anonymity and confidentiality of clients: for instance, by altering some demographic details to disguise their identity.

How will data be stored and used?

We will treat any data you provide us with the utmost care. It will be kept in a secure location at all times (password protected and encrypted computer file and/or locked filing cabinet).

Audio recordings of sessions and interviews, as partially anonymised data, will be kept for a period of ten years before being destroyed. Transcripts of these sessions may be made, and all identifying details of the client (such as a partner's name) will be erased. As fully anonymised data, these transcripts may then be kept for an unlimited period of time.

Clients have the right, at any point during the therapy or after it, to request that all or some of their data be destroyed. If they do so, this will not affect the therapy that they receive.

Clients also have the right, at any point during the therapy sessions, to ask that the recording device is switched off.

Personal details of each client (name and contact details) will be stored separately from other data, and in a password protected, encrypted computer file.

Data may be used for subsequent research projects and data analyses (by persons other than the present Chief Investigator) at the discretion of the Chief Investigator.

Anonymised data may be kept for an unlimited period of time.

Arranging, and preparing for, an initial assessment

If you would like to arrange an initial assessment meeting, please contact Professor Mick Cooper at mick.cooper@roehampton.ac.uk

Who is running the study and who can I contact?

Chief investigator. The person responsible for all research processes is Mick Cooper. Mick is a Professor of Counselling Psychology at the University of Roehampton, and a chartered counselling psychologist. Mick has been in counselling practise for over 15 years, and has authored a wide range of texts on therapy, including *Pluralistic counselling and psychotherapy* (with John McLeod, Sage, 2011).

Further questions. Any questions prior to, during, or after the investigation can be directed to Mick at mick.cooper@roehampton.ac.uk 0208-392 3741.

Independent contact for the research. If you would like to contact an independent person about this research, please contact:

Dr Diane Bray
Department of Psychology
University of Roehampton | London | SW15 4JD
d.bray@roehampton.ac.uk | www.roehampton.ac.uk
Tel: 0208-392 3627

Independent contact for the therapy. In the event that a client feels worse as a result of therapy and would like to talk to someone other than their therapist about it, they can talk, in the first instance, to an independent psychologist who has agreed to act as an initial contact point for further support: Dr Terry Hanley, Terry.Hanley@manchester.ac.uk, (0)161 275 8815. As a psychologist who is independent from this study, Dr Hanley can also be contacted by any participant at any point in time.

Ethical approval. This project has been approved under the procedures of the University of Roehampton's Ethics Committee on the 22nd Dec 2015 (PSYC 15/169).

Appendix A2: Client consent form.



PARTICIPANT CONSENT FORM

Pluralistic therapy for Depression: Research Clinic

This study tests out procedures for offering members of the local community a therapeutic intervention for depression. It is also interested in developing a greater understanding of the process and outcomes of pluralistic therapy -- a collaborative, integrative therapeutic approach -- for people experiencing depression. **For details of the study, please see Information Sheet.**

Investigator Contact Details:

Mick Cooper
Department of Psychology
University of Roehampton
Holybourne Avenue
London SW15 4JD
mick.cooper@roehampton.ac.uk
k
0208 392 3741

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still be used in a collated form. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy. I understand that, in circumstances of serious risk of harm to self or other, my GP may be directly contacted.

Name

Signature

Date

Optional

I give consent for audio recordings of my sessions to be used for teaching and demonstration purposes (please tick)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
---	---------------------------------	--------------------------------

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department.

Head of Department Contact Details:

Dr Diane Bray
Department of Psychology
University of Roehampton
London SW15 4JD
d.bray@roehampton.ac.uk
0208-392 3627

Appendix B: CREST Research Clinic outcome measures

Appendix B1: Goals Form.

Goal Assessment Form v.1

Goal 1:						
Not at all achieved 1	2	3	4	5	6	Completely achieved 7
Goal 2:						
Not at all achieved 1	2	3	4	5	6	Completely achieved 7
Goal 3:						
Not at all achieved 1	2	3	4	5	6	Completely achieved 7
Goal 4:						
Not at all achieved 1	2	3	4	5	6	Completely achieved 7
Goal 5:						
Not at all achieved 1	2	3	4	5	6	Completely achieved 7

Appendix B2: Patient Health Questionnaire, 9-item version.

PATIENT HEALTH QUESTIONNAIRE - 9					72883
THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.					
Were data collected? No <input type="checkbox"/> (provide reason in comments) If Yes , data collected on visit date <input type="checkbox"/> or specify date: _____ <div style="text-align: right; font-size: small;">DD-Mon-YYYY</div>					
Comments:					
Only the patient (subject) should enter information onto this questionnaire.					
Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	
1. Little interest or pleasure in doing things	0	1	2	3	
2. Feeling down, depressed, or hopeless	0	1	2	3	
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3	
4. Feeling tired or having little energy	0	1	2	3	
5. Poor appetite or overeating	0	1	2	3	
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3	
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3	
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3	
					SCORING FOR USE BY STUDY PERSONNEL ONLY 0 + _____ + _____ + _____ =Total Score: _____
<p>If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p> <div style="display: flex; justify-content: space-around; text-align: center;"> <div> Not difficult at all <input type="checkbox"/> </div> <div> Somewhat difficult <input type="checkbox"/> </div> <div> Very difficult <input type="checkbox"/> </div> <div> Extremely difficult <input type="checkbox"/> </div> </div>					
Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. Copyright © 2005 Pfizer, Inc. All rights reserved. Reproduced with permission. EPI0905.PHQ9P					

Appendix B3: Generalized Anxiety Disorder, 7-item version.

GAD-7

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? <i>(Use "✓" to indicate your answer)</i>	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T_____ = ____ + ____ + ____)

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Appendix B4: Session Effectiveness Scale (Client form).

<p>1. Please rate how helpful or hindering to you this session was overall.</p>	<p><input type="checkbox"/>1 Extremely hindering <input type="checkbox"/>2 Greatly hindering <input type="checkbox"/>3 Moderately hindering <input type="checkbox"/>4 Slightly hindering <input type="checkbox"/>5 Neither helpful nor hindering; neutral <input type="checkbox"/>6 Slightly helpful <input type="checkbox"/>7 Moderately helpful <input type="checkbox"/>8 Greatly helpful <input type="checkbox"/>9 Extremely helpful</p>
<p>2. How do you feel about the session you have just completed?</p>	<p><input type="checkbox"/>1 Perfect <input type="checkbox"/>2 Excellent <input type="checkbox"/>3 Very good <input type="checkbox"/>4 Pretty good <input type="checkbox"/>5 Fair <input type="checkbox"/>6 Pretty poor <input type="checkbox"/>7 Very poor</p>
<p>3. How much progress do you feel you made in dealing with your problems in this session?</p>	<p><input type="checkbox"/>1 A great deal of progress <input type="checkbox"/>2 Considerable progress <input type="checkbox"/>3 Moderate progress <input type="checkbox"/>4 Some progress <input type="checkbox"/>5 A little progress <input type="checkbox"/>6 Didn't get anywhere in this session <input type="checkbox"/>7 In some ways my problems have gotten worse this session</p>
<p>4. In this session something shifted for me. I saw something differently or experienced something freshly:</p>	<p><input type="checkbox"/>1 Not at all <input type="checkbox"/>2 Very slightly <input type="checkbox"/>3 Slightly <input type="checkbox"/>4 Somewhat <input type="checkbox"/>5 Moderately <input type="checkbox"/>6 Considerably <input type="checkbox"/>7 Very much</p>

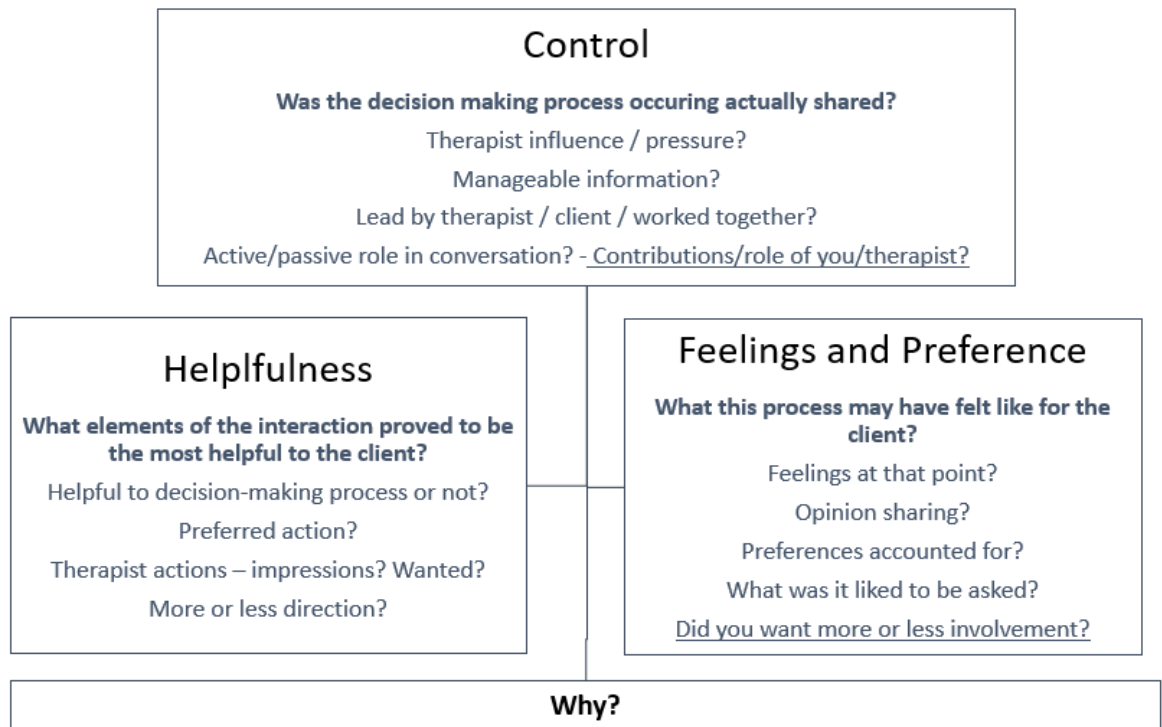
Appendix B5: Session Effectiveness Scale (Therapist form).

<p>1. Please rate how helpful or hindering to the client this session was overall.</p>	<p><input type="checkbox"/>1 Extremely hindering</p> <p><input type="checkbox"/>2 Greatly hindering</p> <p><input type="checkbox"/>3 Moderately hindering</p> <p><input type="checkbox"/>4 Slightly hindering</p> <p><input type="checkbox"/>5 Neither helpful nor hindering; neutral</p> <p><input type="checkbox"/>6 Slightly helpful</p> <p><input type="checkbox"/>7 Moderately helpful</p> <p><input type="checkbox"/>8 Greatly helpful</p> <p><input type="checkbox"/>9 Extremely helpful</p>
<p>2. How do you feel about the session you have just completed?</p>	<p><input type="checkbox"/>1 Perfect</p> <p><input type="checkbox"/>2 Excellent</p> <p><input type="checkbox"/>3 Very good</p> <p><input type="checkbox"/>4 Pretty good</p> <p><input type="checkbox"/>5 Fair</p> <p><input type="checkbox"/>6 Pretty poor</p> <p><input type="checkbox"/>7 Very poor</p>
<p>3. How much progress do you feel the client made in dealing with their problems in this session?</p>	<p><input type="checkbox"/>1 A great deal of progress</p> <p><input type="checkbox"/>2 Considerable progress</p> <p><input type="checkbox"/>3 Moderate progress</p> <p><input type="checkbox"/>4 Some progress</p> <p><input type="checkbox"/>5 A little progress</p> <p><input type="checkbox"/>6 Didn't get anywhere in this session</p> <p><input type="checkbox"/>7 In some ways my problems have gotten worse this session</p>
<p>4. In this session something shifted for the client. They saw something differently or experienced something freshly.</p>	<p><input type="checkbox"/>1 Not at all</p> <p><input type="checkbox"/>2 Very slightly</p> <p><input type="checkbox"/>3 Slightly</p> <p><input type="checkbox"/>4 Somewhat</p> <p><input type="checkbox"/>5 Moderately</p> <p><input type="checkbox"/>6 Considerably</p> <p><input type="checkbox"/>7 Very much</p>

Appendix C: Systematic review search strategy adapted for PubMed

Title OR Abstract	<ol style="list-style-type: none"> 1. shared* 2. co-production 3. person-centred 4. client-centred 5. enhance* and autonomy* 6. "evidence-based patient" 7. mutual 8. co#operative 9. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 10. "decision#making" 11. selection 12. arrangement 13. agreement 14. outcome 15. intention 16. plan 17. choice 18. 10 or 11 or 12 13 or 14 or 15 or 16 or 17 19. meta 20. meta-therapeutic 21. micro 22. 19 or 20 or 21 23. communication 24. collaboration 25. 23 or 24 26. 9 and 18 or 22 and 25
AND	
Date (Publication)	01/01/1990 to present
AND	
All Fields	<ol style="list-style-type: none"> 1. couns* 2. psych* 3. mental 4. therap* 5. 1 or 2 or 3 or 4

Appendix D: IPR prompt sheet



Should they be required, these prompts will include sentence stems to maintain an observing, process focus:

- "As you reflect on that moment in therapy"
- "Taking a step back from that moment"
- Silent or echo probes may be required for clients who are more unfamiliar with the therapeutic process

It may also be necessary to ask after a segment of audio 'Did you see a decision or anything relating to decision making there?'

Appendix E: Review point interview schedule

Appraisal of decisions

1. Were decisions made for your treatment in the last few weeks of sessions since your assessment?
2. How do you feel about these decisions?
3. Did you want to make these decisions?
4. If yes to 1):
 - Reflecting, do you feel these were good or bad decisions? – for each goal / decision / preference?
 - Do you feel these were useful/not decisions for your therapy?
 - Is there anything you would have preferred to have happened differently when making these decisions?
 - Any new goals/preferences that haven't spoken about to therapist?
5. If no to 1):
 - If you didn't set goals/ make decisions, does that still feel okay that you haven't?
 - What made you not want to make decisions?
 - What could have been helpful instead? Or is there anything you would have preferred to have happened differently when (not) making these decisions?
 - Any new goals/preferences that haven't spoken about to therapist?

Relevance

- Is this goal/preference still relevant for your therapy?
- Have any goals/preferences been removed?
 - Which ones? Why?

- Who lead the decision for it to be removed? You/therapist/shared?
- Have any goals/preferences been altered?
 - Which ones? Why?
 - Who was involved in the decision for it to be removed?
You/therapist/shared?

➤ Content about client's life may become quite detailed here. In the event of this, Interviewer to keep client 'on track', yet remain sensitive to the content presented. e.g. redirecting to process past - When you think back to that first assessment session/ decisions made in that first

Importance

- Do you feel it is important for your therapy?
- <Using scores on Goals Form> Do you feel this still holds the same priority for you compared to the other goals?
- <Category score on C-NIP> Do you feel this preference compared to your other preferences is at the same strength as it was?
- <Using IPR transcript> This particular goal or decision was/wasn't immediately recalled by yourself after your assessment session. Why do you think that was?
 - <If WAS> You previously mentioned after your assessment session that the decision to pursue this goal was lead mainly by yourself/therapist/shared, is that so?
 - Did this contribute at all to the importance you placed on it?

New Goals / Changes to C-NIP

- Has anything extra (Goals and then C-NIP) come from the sessions that wasn't previously decided on in the assessment? <Make note of them>
 - For each goal / change to preference:
 - Do you feel the decision to pursue this was mostly lead by you/therapist/shared?
 - Reflecting, do you feel these were good or bad decisions?
 - Do you feel this was useful/not decisions for your therapy?
 - What is the importance of this for you?
 - What is the importance of this compared to your other goals/preference decisions?
- In the event that new goals are discussed with the interviewer and not known to the therapist, clients will be encouraged to bring these to their review session, immediately following the interview.

Appendix F: Shared decision-making observation scale coding by two independent raters

	Coding scores	
	Rater 1	Rater 2
Extract 1	0	0
Extract 2	1	2
Extract 3	1	1
Extract 4	1	1
Extract 5	n/a	-2
Extract 6	0	0
Extract 7	2	2
Extract 8	0	-1
Extract 9	-2	-2
Extract 10	-1	-1

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